

THE NEW DEMOCRAT

FOUR DOLLARS

BLUEPRINT

SPRING 2000

IDEAS FOR A NEW CENTURY

health care igniting a consumer revolution

How we can help ALL Americans

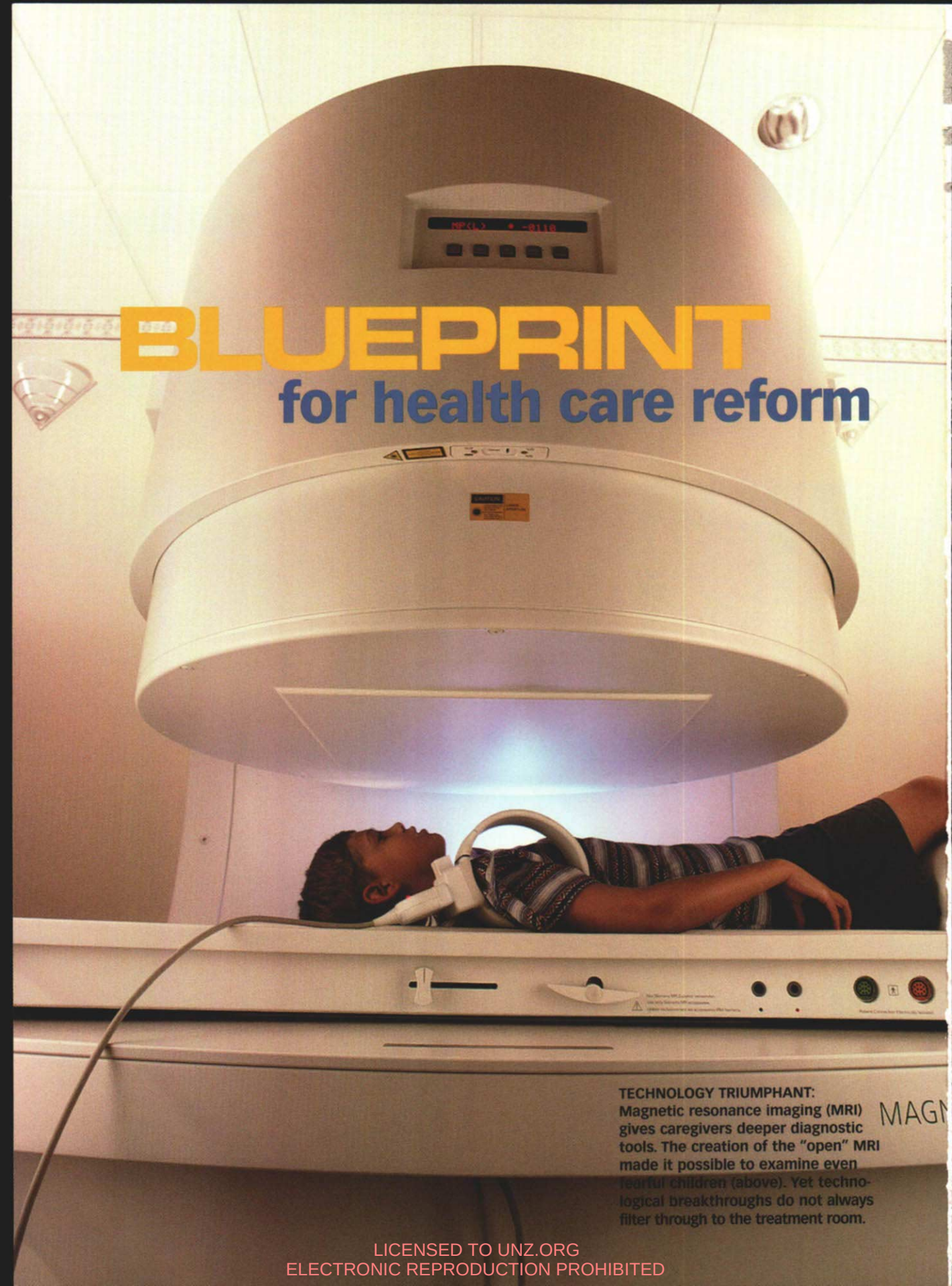
TAKE CHARGE

of their own care. With Senator John Breaux,
S. Robert Levine, MD, Regina Herzlinger,
David Kendall, David Lansky & other reformers.



www.dlc.org/blueprint

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED



BLUEPRINT

for health care reform

TECHNOLOGY TRIUMPHANT:
Magnetic resonance imaging (MRI) gives caregivers deeper diagnostic tools. The creation of the "open" MRI made it possible to examine even fearful children (above). Yet technological breakthroughs do not always filter through to the treatment room.

MAGN

Publisher
Al From

Editor
Peter Ross Range

Issue Editors
S. Robert Levine, David Kendall,
Kerry Tremain, Jeff Lemieux,
Will Marshall

Senior Editorial Consultant
William A. Galston

Editorial Assistant
Michael Yates

Art Director
Kate Rader

Contributing Editors
Chuck Alston, Holly Page,
Debbie Boylan, Andrei Cherny

Board of Advisors
Bernard Schwartz, Chair

Donald A. Baer
John S. Dyson
Christopher Gabrieli
William A. Galston
S. Robert Levine
Dave McCurdy
Regis McKenna
Charles Moskos
David Osborne
Mark J. Penn

Sanford R. Robertson
Thomas B. Ross
Howard Rubin
Daniel Yankelovich
Dorothy Zinberg

Design and Layout
Bloom & Mertz

Copy Editors
Virginia Cope
Hilda Baker

Intern
Chelsea Olson

Health care has clearly moved back to the top of the national political agenda. As both Democratic presidential candidates debate their health care reform plans — and we scrutinize them in this issue of BLUEPRINT — voters focus more and more on how America should address the nagging issues of 44 million uninsured and 98,000 deaths in hospitals from medical error. Amid the clamor for a patients' bill of rights, people seek guidance in the struggle to find choice and control in a system now dominated by insurance companies, employers and health professionals.

This BLUEPRINT shows policymakers how to create a health care revolution that will put people — patients, consumers, health care users — at the center of our health care system, not doctors or insurance companies.

Our writers also show how we can use the tools of modern technology, especially the Internet, to empower ourselves with relevant information to choose caregivers and insurers, get good insurance deals, and seize control of our own health destinies. We learn how we can be assemblers of our own health information databases, making them both portable and permanent.

We also present new ways that professionals and patients can take full advantage of the information cascade that is flowing from advanced medical research. Too often, our authors write, best medical practices established by the latest breakthroughs don't make it to the treatment room where they are needed.

At this critical moment in which health care is meeting the Information Revolution, policymakers face a host of challenges: finding ways to level the playing field for people without employer-provided insurance; mandating individual responsibility for coverage; modernizing Medicare; and promoting a private market in long-term care insurance. They must do all this without provoking political backlash.

In these pages, we've assembled some of the best thinking on how to fix what's broken in our system. We hope both consumers and policymakers can use it to take the first steps toward truly bringing health care delivery into the 21st century.

—Peter Ross Range

Blueprint: Ideas for a New Century is published quarterly by the Democratic Leadership Council, 600 Pennsylvania Ave. S.E., Suite 400, Washington, D.C. 20003. Telephone 202-546-0007. The Democratic Leadership Council is a 501 (c) (4) nonprofit organization. Bulk postage paid at Washington, D.C. The ideas and views expressed in this publication do not necessarily represent official positions of the Democratic Leadership Council, its members, or the Blueprint Board of Advisors. Send all correspondence, remittances, changes of address, and subscription inquiries to: Blueprint, 600 Pennsylvania Ave. S.E., Suite 400, Washington, D.C. 20003.

©2000 by the Democratic Leadership Council.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED



The Health Care Reform Issue

6

1 EDITOR'S NOTE

by Peter Ross Range

Where We Stand

4 44,000,000 / 98,000 — A TALE OF TWO NUMBERS

by Al From

Here are eight steps to start the consumer revolution in health care.

Policy Challenges

8 WHOSE HEALTH IS IT, ANYWAY?

by S. Robert Levine, MD

Managed care and other reforms failed to account for the fact that, just as all politics is local, all health care is personal.

Plus: A health consumer's tool kit

14 "WHERE'S MINE?"

by Michael L. Millenson

For 90 years, reformers have tried to empower consumers with reports on the quality of care. Mostly, they have failed.

16 CAN CONSUMERS JUDGE?

by David Lansky

We already have many of the tools to measure how well doctors perform, but we don't use them.

Plus: A patients' bill of rights? *by Jeff Lemieux*

Failing report cards *by David Lansky*

22 LEVELING THE PLAYING FIELD

by Regina E. Herzlinger

The SEC transformed securities markets during the Great Depression. It's time to do the same for health care markets.

24 GETTING ON THE FAST TRACK TO UNIVERSAL COVERAGE

by David Kendall

Why we need to mandate health insurance for everyone.

Plus: The GOP approach to reform

Pooling resources for the poor *by Fran Carlson*

30 GORE VS. BRADLEY: HOW THEY WOULD COVER THE UNINSURED

by David Kendall and Jeff Lemieux

Solutions

32 REVOLUTION IN MINNESOTA

by Kerry Tremain

Minnesota-based UnitedHealth Group reports on doctors' performance.

Plus: Covering Wisconsin's poor *by Margy Waller*

36 2001: A PERSONAL HEALTH SPACE ODYSSEY

by Katie Donohue

Store your records. Talk to your doctor. Fill a prescription. All online and free, say boosters.

Plus: Is your personal health information *really* safe?

Healthwise makes consumers partners *by Marilyn Snell*

43 MENTAL HEALTH / THE UNRESOLVED AREA OF HEALTH CARE REFORM

The Editors

44 RESOURCE FOR RESEARCH

by Kerry Tremain

NIH's PubMed Central puts life science online.

46 THE DOCTOR IN THE MIRROR

by Michael Castleman

Your most important health care provider is — you.

Plus: Collaborating with your doctor *by Jessie Gruman*

50 THE BLUEPRINT HEALTH INDEX

Startling numbers underscore the urgency of reform.

51 WHAT WORKS / CHATTANOOGA'S OUTREACH PROGRAM

by Judy Packer-Tursman

52 LEARNING HEALTH FOR LIFE

by Judy Packer-Tursman

K-12 health education reduces bad lifestyle choices later on.

54 SAVE MEDICARE FROM ITSELF

by Senator John Breaux

Troubled Medicare can be ushered into the 21st century only by getting politicians out of the medical business.

Plus: A worthy trust fund *and* Finding the will to reform *by Jeff Lemieux*

60 WHAT'S YOUR PLAN?

by Eric B. Schnurer

Most people don't have long-term care insurance, a fact that could bankrupt both government and families.

64 PENN'S POLL — HEALTH CARE IS BACK

76 POST SCRIPT

by David Kendall and S. Robert Levine, MD

44,98,000

Where We Stand

America's health care challenge is a tale of two numbers.

The first figure is 44 million, the stubbornly persistent number of Americans who live without health insurance. And their numbers are growing.

The second figure is 98,000, the number of people who may die every year in hospitals because of medical error. It is the equivalent of a jumbo jet crashing every 36 hours, with no survivors.

The first number is a dragging anchor on our health care system; it reduces efficiency, undermines public health, costs billions, and places a heavy burden on all of the insured who indirectly pay for those without coverage.

The second number is an indictment of the quality of American health care, which fails to match our global leadership in research and technology.

The first number raises the challenge of achieving universal coverage.

The second number poses the question of how to dramatically raise the quality of care.

In this issue of BLUEPRINT, we offer a bold vision for reaching both these goals. Our plan would achieve universal coverage by requiring everyone to buy health insurance, just as drivers must purchase automobile insurance. To make this possible, we would offer tax credits to those who can't afford coverage and don't qualify for other assistance. In addition, we would create new ways to purchase insurance through buying cooperatives run by unions, churches, community organizations, and affinity groups.

To raise quality and improve outcomes, we would harness the power of information and the Internet, giving consumers easy access to data on health care providers, insurance plans, and even their own health records. We would also give providers new requirements to disclose information on what works and what doesn't in health care, forcing them to compete on the basis of quality as well as cost.

On the following pages we present practical steps we can take today to enable a health care revolution by empowered consumers.

by Al From

Al From is president of the Democratic Leadership Council and publisher of BLUEPRINT.

"...the challenge goes beyond patient protections for all Americans in all plans. We must also improve the quality of care."

— President Bill Clinton's statement following the release of the Institute of Medicine report that as many as 98,000 people die each year from preventable medical errors.



8 steps

to start the consumer revolution in health care

"Mandating health insurance the same way we mandate automobile insurance would be a huge step toward universal coverage."

1 **EXPAND OPPORTUNITY TO PURCHASE HEALTH CARE.** Critical to achieving universal coverage is the creation of a market in which everyone has equal insurance opportunity. While most Americans get coverage through their jobs, millions are left out: the self-employed, workers in small enterprises, the unemployed, and the poor. With few options to buy coverage on their own, they need access to the same purchasing power as large employers, through affinity groups. For those who cannot afford insurance, Congress and state governments should provide tax credits and state grants. This would eliminate the gross inequity in our tax system that gives workers a large tax break only if they are provided insurance through employer plans.

2 **DEMAND RESPONSIBILITY BY REQUIRING EVERYONE TO ACQUIRE HEALTH INSURANCE.** Mandating health insurance the same way we mandate automobile insurance would be a huge step toward universal coverage while dramatically widening choice and dampening prices. All individuals would have the responsibility to acquire their own health insurance, whether through jobs or elsewhere. This revolutionary step would be enforced by tax penalties for those who fail to participate.

3 **IMPROVE HEALTH CARE QUALITY THROUGH INFORMATION.** Our system is crippled by opaque communication and poor information-sharing. If we harness modern technology and the Internet to empower consumers through knowledge and choice, they can demand, and get, better quality care. With knowledge, consumers can make informed choices that will drive the insurance market in their favor, change incentives for doctors and hospitals, and create consumer-oriented health care. To encourage full disclosure of medical mistakes and honest report cards on treatment outcomes, we should break down barriers created by the fear of lawsuits. Rather than writing those report cards, federal and state governments should stimulate a competitive market in information. A health care commission like the Securities and Exchange Commission can oversee the process, guaranteeing fairness.

4 **MODERNIZE MEDICARE.** We should use market competition to control costs while providing better benefits for seniors, including prescription drugs. A good reform model is the Federal Employees Health Benefits (FEHB) program, which offers a wide variety of insurance choices to federal workers. FEHB relies on competition among private health plans rather than a bureaucracy to hold down costs and encourage innovation. By bringing the buying power of 40 million older Americans into a similar competitive market place, price increases will be dampened.



5 FOSTER A MARKET FOR PRIVATE LONG-TERM CARE INSURANCE. Everyone must take responsibility for his or her long-term care needs. Government can help by giving people the opportunity to purchase coverage through a payroll deduction where they work or through buying cooperatives. We need to close the back door entitlement that allows even affluent families to use Medicaid for their long-term care. The long-term care part of Medicaid should only subsidize private insurance for people who cannot afford coverage.

6 BUILD COMMUNITIES OF HEALTH. Let's increase support for successful programs in our distressed community-based health infrastructure: public health clinics, health education programs, anti-drug campaigns, crisis hotlines. Ongoing evaluation should direct resources to programs that work and eliminate those that fail. We need to move public health toward "high tech, high touch" using computer technology to speed and personalize interaction between consumers and caregivers. As it did with the Internet, the government can facilitate community-based networks of support. It can also catalyze online "personal health spaces," secure Web sites where consumers can store private health records, consult their doctors, and conduct all of their health care business if they wish.

7 START HEALTH EMPOWERMENT IN KINDERGARTEN. Good health is a skill to be learned, just like baseball, math, and language. Self-care must be a lifelong undertaking, like reading. It's not enough to have an occasional health day in grade school or one health course in high school. Health education must be incorporated in every subject from English (stories about surviving cancer) to math (how to use nutrition labels) and in the school environment itself (healthy food in the cafeteria and daily physical education).

8 SUSTAIN THE FEDERAL COMMITMENT TO HEALTH RESEARCH. Information-empowered consumers need reliable and current research data to make informed choices. If we are to offer real choices and reduce deaths due to ignorance and medical error, we must maintain a high level of research funding while finding effective ways to quickly translate new knowledge into better quality health care.

With universal coverage and a consumer-empowered health care system, Americans can finally get the health care they deserve. By making affordable health care available to everyone through tax credits or buying cooperatives, we empower individuals to take responsibility for their own coverage. By turning health care into a market-driven service in an information-rich environment with government protections against abuse, professionals will feel more accountable to patients, and health insurers will be more responsive to consumers' unique needs and preferences. Universal coverage, coupled with consumer empowerment, is the strong medicine we need now to make our health care system healthy. ■

"We need to move public health toward 'high tech, high touch' using computer technology to speed and personalize interaction between consumers and caregivers."

Whose health is it, anyway?

by S. Robert Levine, MD

In 1993, Sandra Silvestri's 2-year-old son Joey was diagnosed with Type 1 diabetes. Today, she reflects on the calamity of Joey's illness and the promise of medical research: "We carried him into the emergency room, near death, and literally placed him in the arms of the health care system. From this moment on our family has been dependent on the health care system to keep our son alive. Research is an extension of this lifeline."

Public investment in basic research during the past century produced breathtaking advances in our fundamental understanding of life, health, and illness. Coupled with new tools recently developed in the public and private sectors — such as genetic engineering and rational drug design — this new knowledge puts us on the threshold of solving many of our most serious health problems. Joey Silvestri's diabetes may be cured by a new ability to replace the insulin-producing pancreas cells he lost to autoimmune attack with new ones. Spinal-injury patients may soon be able to regenerate nerves and walk again. In the not-too-distant future, we will even be able to create genetic health profiles of individuals to allow us to better predict risk of illness — then design personalized interventions to prevent disease from occurring.

Yet despite these medical advances, the American system of health care is a dissonant mix of promise and peril. The promise of our current capabilities and research is betrayed by the daily reality of our health care delivery system. The peril comes in many forms: the celebrated surgeon who cures a cancer yet fails to recognize a

S. Robert Levine is a cardiologist and leader in the movement toward a consumer-driven health care system. He is chairman of Decision Support Systems, Inc., a start-up Internet company which will provide personalized health services.





Managed care and
other reforms failed to
account for the fact
that, just as all politics
is local, all health care
is personal.

The health consumer's tool kit



How to put individuals in charge

1. Personal Buying Power

When consumers make the decisions about who gets paid how much money, doctors, hospitals and insurers will start serving them better. Simple as that. By giving consumers tax credits, government can get more buying power in the hands of individuals and level the tax subsidy playing field.

2. Quality Information

There are countless places to go for information about buying consumer electronics or mutual funds — why is there so little on hospitals and health plans? An SEC-like health commission could catalyze competition to provide the best information to consumers in a form they can use.

3. Someone to Trust

Community organizations, public and private, can assist consumers in getting what they need from the health care system. They can help individuals find pertinent information to deal with chronic illness, recovery, rehabilitation, and life changes.

4. A Personal Health Space

Imagine a secure place on the Internet where individuals could keep and control access to their health records — a private Web site where they could confidently communicate with providers, experts, and other consumers with similar problems. In this virtual health space, they could also purchase insurance, file claims and appeals, and buy or exchange health-related products and services. A personal health space would allow them to get appraisals of their health risk, learn about disease prevention and self-treatment, and participate in research studies. And they could receive regular updates on issues that affect them, including new care options and the recognized best treatments. Sound good? It may be coming to a cyberspace near you.

post-op drug allergy; the primary care physician who fails to recommend a proven life-saving treatment for a common health problem; the trusted neighborhood pharmacist who can't read a physician's hasty handwriting on a prescription and dispenses an incorrect drug that proves fatal; the insurance claims agent who refuses to approve a needed service.

Nowhere is our system's failure made more plain than in the 1999 Institute of Medicine report showing that as many as 98,000 people die in hospitals each year from medical error. "Despite the cost pressures, liability constraints, resistance to change, and other seemingly insurmountable barriers, it is simply not acceptable for patients to be harmed by the same health system that is supposed to offer healing and comfort," stated the report.

Why such a profound disconnect between our abilities and our performance? It's not that our core values are wrong. Health professionals know it is their special duty to provide counsel and comfort at the highest level possible, based on the best available knowledge and resources. They understand that it is not enough to "first, do no harm" (which we don't yet do well). It is necessary to "always do better." But the obstacles to quality and safety are deeply imbedded in our health system's focus, infrastructure, and incentives.

At its leading-edge, the practice of medicine changes rapidly, often outrunning our capacity to systematically evaluate the impact of these changes on individual outcomes or disseminate widely what we learn. In addition, many modern interventions are complex, requiring precise coordination and interaction with multiple providers and intermediaries, increasing the potential for errors.

To keep pace, efforts to improve quality and outcomes cannot be occasional or retrospective. They must be an ongoing priority for everyone in the system, including consumers. Medical safety and quality improvement have to be part of the culture of medical practice. Institutions and incentives have to be aligned to put patient out-



NEW CURES: The hope fostered by our remarkable progress in medicine, like this use of laparoscopic surgery, is betrayed by the day-to-day reality of our health delivery system.

swung to domination by the managed care health plans. This swing was misguided. It failed to account for the fact that just as all politics is local, all health care is personal. People are the true center of our system and individual experiences are the citizenry's units of measure. Only by shifting to a people-centered system — with consumers as well-informed, fully empowered collaborators in their care, with real options and control over their choices — can our system begin to meet its promise.

Recently, with the popular clamor for a “patients’ bill of rights,” the power pendulum began swinging away from managed care. But what we really need is a transfer of the deed of health ownership. Individuals

“Why such a profound disconnect between our abilities and our performance? The answer lies in the distorted power relationships among the stakeholders in our health care system: patients (consumers), providers (hospitals, doctors), and insurers.”

comes at the top of everyone’s priority list.

This requires a realignment of the incentives in our system to promote a focus on outcomes and information sharing. Evaluation of clinical results and assessment of the cause of medical errors must be conducted in the context of learning for improvement, not judging for blame, punishment, or liability. Further, without proper recognition for achievement of quality goals, even the most dedicated professionals and institutions will burn out and default to the status quo.

Realigning incentives means reshaping the distorted power relationships among the three principal stakeholders in our health care system: patients (consumers), health care providers (doctors, hospitals, therapists), and payers (employers, insurance companies). We need a new health care balance of power that rewards personal responsibility and professional accountability, while offering consumers real choice.

For the better part of the past century, control of the system rested largely in the hands of the providers — the “knowing others” who bestowed their unfathomable wisdom on passive recipients, the patients. Then, because of runaway costs, the pendulum

own their health, not providers or payers.

Consumers have the biggest stake (and are at the greatest risk) in our health care system’s quality performance. Consumers alone are fueled by the passion and urgency that result from living with the effects of illness, or seeing their loved ones suffer. They are the engine for change that can drive outcomes improvement, encourage timely use of new knowledge, and demand mechanisms to evaluate the effects.

To become effective change agents, however, consumers must evolve from passive recipients to informed partners at the center of the system. To evolve they must be empowered — with access, information, and choice.

As a first step, consumers should be able to shop for individual health care plans on the open market, at competitive prices, the same way their employers now shop for group plans. But to do this, consumers need control of their health insurance buying power; they need to know which insurance plans have performed best, for the lowest price, in the eyes of other consumers. They need to see performance ratings for doctors and hospitals. And they need access to communities of concern that can help support their decisionmaking.

"The United States has achieved global leadership in computers, aerospace, and biotechnology. But in health care we've failed to marry scientific advances to continuous quality enhancement."

One of the great promises of the Information Age is the opportunity to shift from a system that is opaque and narrow to one that is transparent and spacious. This means changing a health care environment that is characterized by very limited access to outcomes information and consumer satisfaction reports to one that is information-rich; from one with dangerously variable quality to one that provides it consistently; from one with limited choices to one that promotes individual choice.

The Internet, with its unique capacity to enable connectivity between all stakeholders, can enable such a movement. It allows mass customization so all activities can be centered on the individual. It further creates opportunities to prospectively generate and disseminate outcomes data. It provides a platform for health care research and sharing of new knowledge.

Every consumer should be able to create a personal health space (PHS) on the Internet. A PHS would be each person's virtual health space, a private online location for storing (and sharing) personal health information — and a secure portal for accessing everything else available in cyberspace to enhance health. A person could interact with doctors and other caregivers; call up information on self-care; find support for healthy behavior change; and even access the work of top experts in a field. More important, consumers — like the professionals who serve them — would have access to the latest research on best practices, performance, and outcomes. Not only would that create a better-informed, self-caring consumer, but it would have a sobering effect on the care-giving community. No longer could physicians, for instance, regard their patients as uninformed recipients of superior knowledge from the doctor; they would have to treat them more like equal partners in the search for good health.

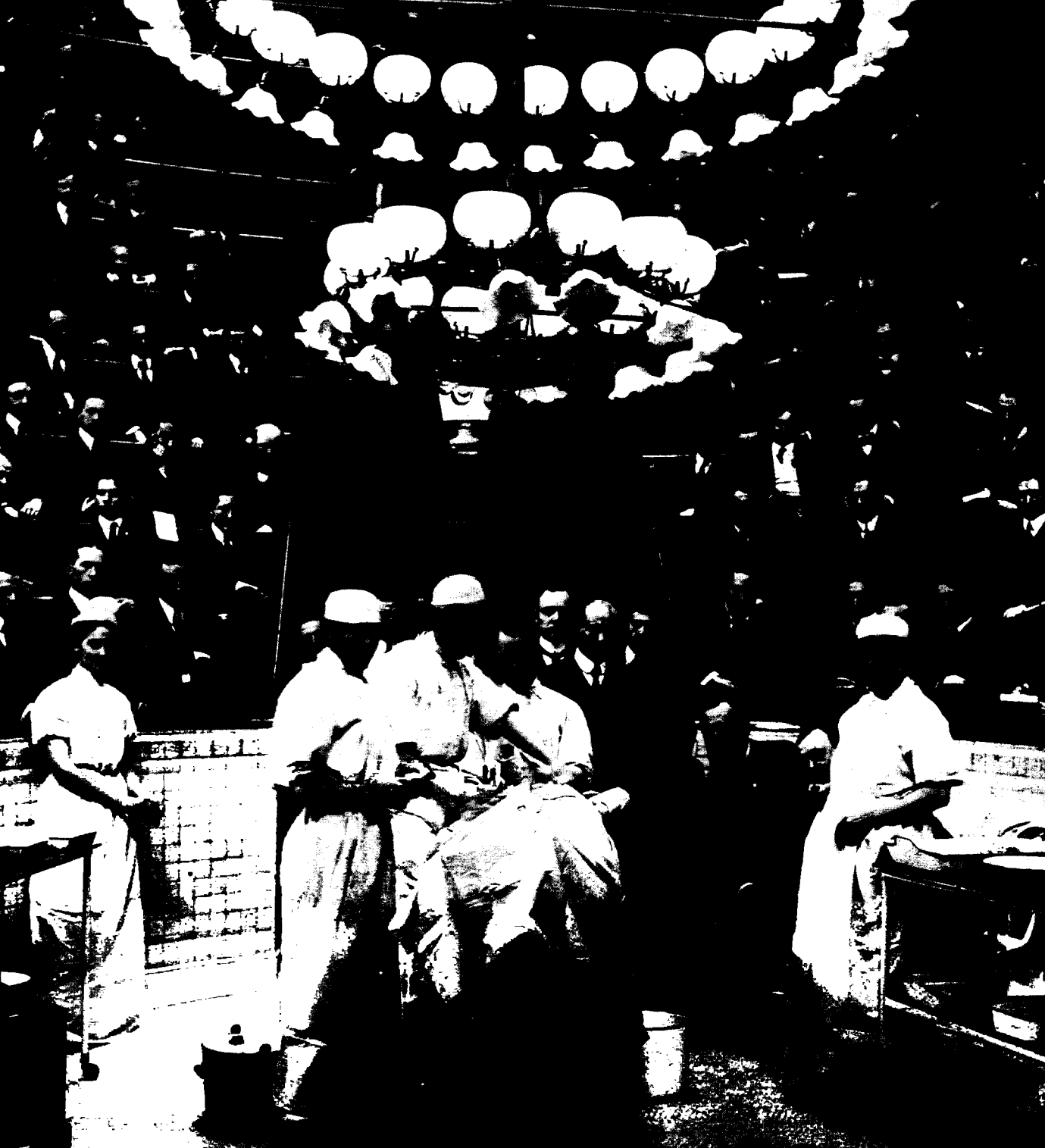
Issues of privacy and liability are daunting short-term roadblocks to the creation of truly secure personal health spaces. But they are solvable over time and once they are resolved, a secure online marketplace can emerge where users will easily access information about benefits, eligibility for public programs, and

performance. Consumers will be able to track health status and expenditures, reconcile claims questions, know their rights, and have instant access to external appeals. They will be able to read the evaluations of insurers, providers, and sellers of health care products and services, and make purchases online. And they will be able to confidently interact with providers, caregivers, and their own personal health communities.

A person-centered health system is possible. It will foster a sense of personal control that will encourage consumers to play a larger role in caring for their own health, including much needed behavior modifications. (Half of all deaths in the United States have been attributed to tobacco, drugs, alcohol, diet, motor vehicle accidents, sexual behavior, and activity patterns, all avoidable through lifestyle changes.) A person-centered system will also enhance communication between all health stakeholders and help rebuild our trust and confidence in professionals and health care institutions.

The United States has achieved global leadership in a remarkable number of areas, from computers to aerospace to biotechnology. But in health care we've failed to marry our remarkable scientific advances to the techniques of process improvement and continuous quality enhancement; we have not fully realized the promise of our health system. Where other industries profited from the quality improvement lessons of industrial theorist W. Edwards Deming, health care has remained bogged down in old practices and stifled by historic inhibitions (such as its fear of openly reporting errors for the purpose of improvement). Yet with restructuring incentives and altered power relationships, there is no reason why our health care system cannot reach the same levels of efficiency, quality, and satisfaction as in other industries. When our system changes as dramatically as medical knowledge has changed, we will realize the potential we have invested so much in developing.

By putting the individual at the center of the system, we can begin to achieve our goals: universal access to high quality, affordable health care, and the opportunity for everyone to achieve optimal health-related quality of life and function. ■



In his important report of 1910, Adams said that the purpose of the work is to educate the people of the United States in the use of existing scientific knowledge and to give them the best aid which is possible to give them in the practice of medicine. Nearly 70



Dr. Vergil Slee (above) believed hospitals would voluntarily share quality information with the public. He was wrong.

“Where’s mine?”

For 90 years, reformers have tried to empower consumers with reports on the quality of care. Mostly, they have failed.

by Michael L. Millenson

In 1954, a University of Michigan professor of public health, Dr. Vergil Slee, persuaded a group of hospitals in the state to collect standardized patient care information and code it onto computer punch cards. With that data, Slee created what he called his Professional Activity Study (PAS) system so the hospitals could compare themselves to one another. He hoped that medical staffs would use PAS to analyze individual physician performance in order to improve their practice. And he believed hospitals would voluntarily share quality information with the public.

Unfortunately, this optimistic scenario was (and is) wildly off the mark. Why?

Slee’s efforts were idealistic, and although he was a physician and an academic, his failure and the repeated failure of similar initiatives can be best described in the blunt language of rough-and-tumble Chicago politics. The Vergil Slee of the health policy world are what Chicagoans would call the “goo-goos,” the “good government” types enamored of rationality and sharing power among providers and patients. Their opponents are physicians and hospitals who have a deeply vested interest in the status quo — their systems, their methods, and their practices. Like the aldermanic pinky-ring set so vividly described by the late columnist Mike Royko, they were always asking, “Where’s mine?”

The history of health care reform in this century is largely the story of the established interests winning out over

the rationalist reformers.

In 1910, the renowned Flexner Report called for standardizing medical education around scientific principles. By embracing the report, the medical establishment raised the quality of medical training. The reform also eliminated non-accredited medical schools that churned out competitors to the “scientific” physicians. On the other hand, a proposal in 1912 by Harvard-trained surgeon E. A. Codman to standardize medical practice (as opposed to medical education) and then provide patients with information on comparative performance went nowhere. The medical community wanted no breaches in the long-held party line of its calling, that all doctors who come out of accredited medical schools are good. Rating some physicians as better or worse than others would breach professional solidarity.

By mid-century, public demand for postwar wonder cures was so intense that there were not enough physicians and hospital beds to go around. That was when Vergil Slee’s Professional Activity System came along, a flashing yellow light cautioning patients to temper their unbridled enthusiasm for medical intervention. In one of Slee’s studies, for example, he showed that one-third of the surgeons who performed appendectomies were consistently wrong in their diagnoses. Yet Slee’s pleas for standardized care and performance ratings went unheard in the fast-growth atmosphere of the day. Medicine was a seller’s market. Under the then-dominant fee-for-

service system, where more surgeries meant more profit, the self-aggrandizing ethos won out. Slee’s plan was about as popular in the medical world as an honest building inspector on the streets of Chicago.

In 1998, at the height of the HMO backlash, both President Clinton’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry and the Institute of Medicine’s National Roundtable on Health Care Quality came out with near-identical reports. Both concluded that it wasn’t managed care that was the problem, but how providers and consumers used medical services. Yet because there was little incentive for the providers or HMOs to take any action on the results, nothing happened. Patients were not given ways of seeking out good, better, and best providers. Most health plans continued to offer the largest possible networks of doctors and hospitals — an updated version of the “all doctors are equal” ethos. Even the liberal and conservative interest groups leading the fight against perceived HMO abuses showed little interest in changing the political discussion from the evils of managed care to the foibles of individual doctors. After all, bashing HMOs had filled their coffers.

Yet for all the resistance to change, the rationalists didn’t always lose. In the early 1970s, unnecessary surgeries emerged as a hot political issue. While pointless tonsillectomies, for example, had been a well-known medical problem for decades, the appearance before a

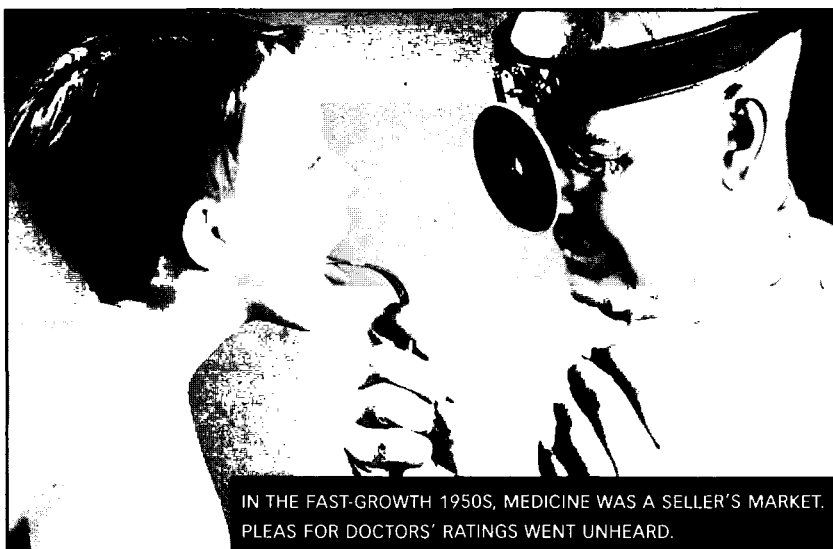
crowded House hearing of a mother whose child had died from complications following an unneeded tonsillectomy provided a burst of incentive for self-policing.

Reform arguments also work if they bring in money. In the 1960s, hospitals that wanted to receive Medicare funds were forced to get accreditation from either a state health department audit or from an accrediting organization dominated by the health care industry. The industry process quickly became very popular. Similarly, health plans jumped on the accreditation bandwagon in the 1990s when a coalition of powerful large corporations threatened to pull its business from anyone who didn't make the grade.

While this quick history of quality improvement might seem pessimistic, there is actually reason for hope. The forces for altering the old ways of doing business are gathering steam.

For example, "performance-based organizations" are becoming the norm in areas once thought impervious to measurement, including education and government agencies (at the initiative of Vice President Gore). In this kind of environment, how long can the local hospital, health plan, or physician group continue to plead ignorance about the appropriateness and effectiveness of its care?

Just as important, the technology for measurement has become ubiquitous. In Slee's time, doctors feared computers as something unknown. Twenty years later, they dreaded them as a possible replacement for physicians. Today, a growing cadre of physicians sees computers differently. Doctors understand that computers can become allies in helping them practice cost-effective, high-quality care, thus fending off micro-management by health plans. Tracking outcomes and rating performance are inevitable in a digitized world. The academic successors to



IN THE FAST-GROWTH 1950S, MEDICINE WAS A SELLER'S MARKET. PLEAS FOR DOCTORS' RATINGS WENT UNHEARD.

There is actually reason for hope. Forces for altering the old ways of doing business are gathering steam. Performance-based organizations are becoming the norm in areas once thought impervious to measurement, including education and government.

Vergil Slee are even gaining new respect. One start-up company working with the Medical Informatics Department at the University of Utah offers doctors an Internet site that allows them to match their patients' specific risk factors and clinical findings with the latest treatment guidelines. Slee's vision of guiding the individual practitioner with cumulative data and success rates from a large number of providers is now possible.

With the Internet, hospitals and doctors can no longer exclusively control the flow of information to patients. Once online, a Professional Activity Study like Slee's is available not just to doctors but to everyone. This pushes providers toward change because of a new form of competition — from the consumers. When a physician sees patients walking in the door with the latest clinical guidelines and outcomes downloaded on their Palm Pilots, he may feel the need to start visiting the appropriate Web site before

they arrive.

When the forces of technology and social change combine in just the right way, the "where's mine?" set and the "goo-goos" can sometimes find a startlingly common interest. "Behavior follows rewards" is a maxim of the marketplace. In the Information Age, economic interest dictates that providers and health plans prove that they deliver value for the dollar. To do so, they must embrace the quality improvement regimen beloved by the rationalists. If they do, well-informed buyers of high-value health care will finally become an accepted part of mainstream medicine.

Michael L. Millenson is a principal in the health care and group benefits practice of William M. Mercer Inc. and the author of Demanding Medical Excellence: Doctors and Accountability in the Information Age (University of Chicago Press).



We already have many of the tools to measure how well doctors perform, but we don't use them. As a result, we have failed to create a health care system based on excellence.

Can consumers judge?

by David Lansky

Many Americans were shocked by the 1999 Institute of Medicine Report that as many as 98,000 Americans die from medical error every year during hospital stays — the equivalent of a jumbo jet crashing every 36 hours. More shocking, however, is the fact that the health care community has known about these persistent problems for years and failed to correct them.

Far too many Americans don't get the basic care recommended by best medical practices; much of the care they do receive is wildly unpredictable. Only about 21 percent of patients are given the right medications after they have been hospitalized for heart attacks. Just as bad, only 17 percent to 50 percent of older Americans with diabetes have their eyes and their blood sugar levels checked routinely for early signs of complications.

There are other inequities in our health care system. Often, "geography is destiny," as one researcher put it. For instance, a woman with early-stage breast cancer would be four times more likely to undergo a mastectomy if she lived in Augusta, Ga., than if she lived in Pittsburgh.

Despite the fact that the United States spends 15 percent of its gross domestic product on health care — at least 50 percent more per capita than any other industrialized country — we have failed to create a health system that is focused on excellence. Why?

Incredibly, the United States has no adequate way of recognizing and rewarding excellence in its health care system. None of us — not the patients, not the doctors, not the insurers, not the

David Lansky is president of the Foundation for Accountability (FACCT), a nonprofit organization dedicated to helping consumers make better health care decisions.



HOW TO CHOOSE?
Beseiged with marketing,
consumers crave
knowledge instead.

*"It's one thing to
measure performance,
but another to put
that information into
a form that patients
can use."*

government — knows where to find better quality care in any community. Good providers are rarely rewarded with more patients, more money, or more status. It doesn't have to be that way.

The way to improve American health care is to measure which doctors, hospitals, and health plans do the best job, then provide that information to consumers so they can seek out the care that is best for them.

But how should we define and measure quality?

Both consumers and experts have important things to say about quality. Patients want to know that they are receiving care consistent with the "best practices" defined by researchers and doctors: regular tests, access to new medications, use of effective procedures. Patients also say that their doctors need to listen to them, understand their lives, and help them function well day-to-day. Those caregiving skills are as important as good medical care, say the patients, because if people don't trust their doctors' judgment,

they simply don't tell them all the facts, follow their advice, or take the recommended medications.

Here's a simple example. People with severe asthma should have a peak flow meter they can use to monitor themselves and an inhaler to get medication when needed. About two-thirds of diagnosed, insured, severe asthma patients say they have a peak flow meter, and over 90 percent have an inhaler. But only about 40 percent of those patients say they know how to use the meter, and only one-fourth actually use it. Thus, about 70 percent of the medicine in the canisters never reaches the patients' airways. As a result, people with asthma continue to miss work and school and swamp urban emergency rooms with unnecessary visits.

Imagine if we knew which doctors and nurses were most successful at making sure their asthma patients knew how to take care of themselves. These might be professionals who speak Spanish or Russian—the languages of immigrant patients — or who take a few

extra minutes to watch a patient use the inhaler or who hire a skilled nurse educator to call patients at home. Patients could seek them out, insurers would pay them a bonus, colleagues might try to learn from them. As a result, the level of care throughout the community would improve.

Today, none of that happens.

We already have many of the tools to measure how well doctors and others provide optimal medical care and how well they address the needs and values of their patients. We have standard ways to measure quality for illnesses like breast cancer and diabetes and for key life stages like adolescence and care at the end of life.

For example, diabetes affects only about 3 percent of Americans — but accounts for more than 12 percent of total medical costs. With good care, patients learn to keep their blood sugar in a controlled range and dramatically reduce the risk of blindness, amputation, or serious kidney problems. Doctors should see patients frequently, order vital blood tests, prescribe key medications, and check for early signs of complications. They should help patients manage their diets, increase their exercise levels, and learn how to monitor their own blood levels every day. We now have precise ways of measuring how well these practices are being done. We can measure the proportion of a doctor's diabetes patients who have blood sugar levels below the critical values, and we can measure the percentage of patients who know how to monitor themselves at home. On these measurements, some doctors do more than twice as well as others.

It's one thing to measure the performance of our doctors and health plans, but another to put that information into a form that most patients can use to find the right care for themselves.

Fortunately, researchers have developed ways to present quality information so that most people can understand and use it. Simple indices can tell people whether doctors and health plans will help them stay healthy, live with illness, and get bet-

A patients' bill of rights

by Jeff Lemieux



A debate about power relationships

Will a patients' bill of rights improve the quality of care patients receive? Probably not. Discussion of quality health care has been all but lost in the national debate over patients' rights. Today the political debate is mostly about power relationships, with doctors and lawyers pitted against managed care plans and employers. Patients and their concerns have been bumped aside as the big players throw their weight around.

The patients' rights bills before Congress seek to authorize new regulations by the Department of Labor and the Health Care Financing Administration and new lawsuits against health plans. Empowering bureaucrats and trial lawyers may end a few abuses, but real progress and quality improvements will be driven by the free flow of information,

not by regulation and litigation.

But how will patients get the comparative information they need? Health care providers are not about to disclose information on the quality of care until they are relieved of at least some liability for their misjudgments or mistakes.

To make a patient-centered health system work, we must break the climate of blame and distrust. To gain the full participation of providers, we need to promote a culture of learning for improvement as opposed to one of judging for blame and punishment. Like

airlines following a crash, medical institutions need to be willing to thoroughly investigate their disasters, fully disclose the results, and make appropriate improvements.

Exactly how to replace individual liability with information is not yet clear. Concepts like no-fault liability insurance and enterprise-wide liability are possible alternatives to some individual malpractice suits. Clearly, lawsuits and criminal punishment should still apply in some cases. Furthermore, patients must be sure that health care providers with low skills are quickly ushered into other professions.

New Democrats should look beyond the patients' bill of rights to initiatives — such as Regina Herzlinger's proposal for an SEC-like health care commission on p. 22 — that are less likely to inflate health costs and more likely to improve the quality of care patients actually receive.

Jeff Lemieux is the senior economist at the Progressive Policy Institute.

"Patients and their concerns have been bumped aside as the big players throw their weight around."

Failing report cards

by David Lansky



To be effective, they need to be based on the concerns of the patient

In the last few years, many "report cards" on health care have appeared. So far, however, these report cards get a "B" for effort and a "D" for effectiveness.

The problem with the existing report cards is that they generally depend on two sources of information: the Consumer Assessment of Health Plans Survey (CAHPS) and the Healthcare Employer Data Indicator Set (HEDIS). CAHPS conducts patient surveys about service — getting appointments promptly, being treated with respect, claims processing times, and the like. HEDIS measures 60 clinical processes, like immunizations for children and mammograms for women over age 50.

But both efforts suffer from debilitating limitations.

First, these tools were based on the concerns of the industry, not the patients. They emphasize public health issues such as mammograms. But if you have a diagnosis of breast cancer or your child has asthma, you won't find any information in these surveys to help you. Furthermore, the data are presented in tables and charts that are often technical, very specific, and hard to understand. So people rarely use them.

Even if they were more useable, these reports only assess HMOs; only about half of them report their data to HEDIS and CAHPS. And only two-thirds of those allow the data to be disclosed to the public. The reports do not address other types of insurance plans, and they certainly do not rate doctors or hospitals. Most people want to compare the quality of all their insurance options, and are particularly interested in which doctors might best meet their needs. They need an entirely different kind of report card.

Finally, few consumers think of health care as a "system." They think about whether their doctor is "good" and how well he treats them. To be meaningful, report cards need to be part of a comprehensive, year-round strategy of consumer education and communication. They will have to include information that is easy to understand, presented in a tailored, personalized form, and addresses all of the available options. Ultimately, they must have something that helps them make important health care choices.

"Most people want to compare the quality of all their insurance options.... They need an entirely different type of report card."

ter. And simple displays have been developed and widely tested for communicating clearly with consumers. However, so far the early experiments in producing public "report cards" on health care providers have had very little impact. In part, that's because the industry controls the evaluation process (see "Report Cards," p. 20).

Many health care insurers and providers oppose public accountability. They insist that any reporting must be voluntary, and are unwilling to collect and report their own outcomes.

The three major auto manufacturers jointly asked the major national preferred provider organization (PPO) insurance plans to publish member satisfaction data — and were refused. In a recent survey, only 2 percent of employers said they use available quality information to influence their health care decisions.

The federal government stopped publishing hospital death rates after the hospital industry protested. The national reporting system on health maintenance organizations (HMOs) is voluntary. Indemnity insurers (including traditional Medicare) and PPOs, the fastest growing type of insurance, oppose any public information requirements. Neither Medicare nor the Federal Employee Health Benefits Program has been able to require more than the most superficial information to be disclosed — and the government has had to pay all the data collection costs for that!

Only a standardized national reporting system will overcome this political opposition. If the federal government mandated disclosure of a minimum set of performance indicators, the information industry would eagerly compete to help consumers acquire, interpret, and make decisions from those data.

These barriers won't be overcome through exhortation or incremental reform or health plan report cards. American consumers must assert a right to know what kind of care they are getting and to choose the caregivers who meet their personal needs. Three things are necessary to generate public outrage:

Public leadership. Community leaders need to tell the public that quality can be better, that they should demand quality care, and that they have a right to the information that would allow them to seek it out.

Access to useful and understandable information. Public agencies, employers, consumers, and health care organizations must collaborate to produce information that matters to people. Government agencies should only contract with health care organizations that disclose how public funds are spent and what health benefits are achieved by their patients and members. Publishers should agree to use simple conventions in communicating with the public. Understanding your health care should be as easy as reading a nutrition label on a soup can or the fuel efficiency rating of a new car.

Meaningful choices. Many health plans sign up the same groups of doctors and hospitals, so choosing one health plan over another does not solve the quality problem. Consumers must have accurate and reliable information on cost and quality to discriminate among doctors, hospitals, and health plans.

Government has an essential role to play in creating an environment that rewards excellence. First, governments are major purchasers. They can work with employers or other purchasers to require disclosure of quality of care, and they can ensure that performance information is widely publicized. As performance data emerges, governments care and terminate plans that fail to meet minimal standards.

Second, government leaders should tell consumers that they have a right to make important decisions for themselves and that relevant, important information exists to guide them toward the best choices. Quality deficiencies need to be exposed, and the public must be told that better care is possible.

Both of these strategies drive us toward a health care system that allows all Americans to understand the importance of quality care for their lives and then demand and seek it out. In our democratic, information-rich society, there is no other way to create a responsive and humane health care system. ■



Practice makes perfect

According to researchers, nothing predicts quality care as well as the number of times the doctor or hospital has performed a procedure. In 1984, the Texas Heart Institute (THI), led by famed heart surgeon Denton Cooley (above), began an all-inclusive system for selected cardiovascular surgeries. In response to THI's apparent success in containing costs while delivering superior outcomes, Medicare launched a demonstration project to test the new approach in 1996. A summary of findings showed significantly lower mortality rates compared with Medicare national rates and an over \$50 million reduction on bypass patients treated in the demonstration project. As surgical skills improved, the hospital saw substantial declines in follow-up recovery costs, nursing expenses, and pharmacy and laboratory costs. Patients were able to go home sooner and healthier. Positive results have been achieved with so-called "focus factories" for cataract surgeries and other procedures.



"[The SEC] puts the burden of telling the truth on the seller."

— Franklin D. Roosevelt, 1934

Leveling the playing field

The SEC transformed securities markets during the Great Depression. It's time to do the same for health care markets.

by Regina E. Herzlinger

The managed care backlash has clearly arrived. Alarmed by the prospect of denial of needed care, consumers are expressing outrage at HMO "just-say-no" policies. Elected representatives have rushed to the rescue with well-intentioned regulations, from a patients' bill of rights to mandated benefits. But regulation is no surefire problem solver. Regulations can ossify institutions and suppress much-needed innovation, and they can be politicized.

Fortunately, another sector of the economy offers valuable lessons for effectively resolving similar problems. Although at one time it, too, suffered from lack of public trust and was thought to damage American consumers, it is now among the most admired parts of our economy: the U.S. securities markets.

Founded in 1934 in the heart of the Great Depression, the Securities and Exchange Commission (SEC) transformed then-beleaguered U.S. securities markets into today's vaunted efficient markets. Creating a new health care insurance commission modeled on the SEC can do the same today for health care markets.

Building on the SEC's full disclosure and oversight model — putting "the burden of telling the truth on the seller," in President Franklin D. Roosevelt's memorable words — a health care insurance commission could require transparency, integrity, and independent auditing of

information provided by health insurers. It could mandate public disclosure of all health insurance prices, transaction costs, and coverages and require reports on provider quality and customer satisfaction in a form that permits easy comparison shopping by consumers.

Consumers need specific, timely information to readily identify the health professionals who can best treat them. They want the same kind of multiple perspectives available to investors, who can choose from hundreds of excellent sources of information, ranging from Morningstar for mutual funds to easily available public media analysts.

The key to the success of a health care commission like the SEC is not for government to evaluate individual products or micro-manage markets. Rather, government should build a level playing field in which private sources compete to provide more useful and accurate information. That in turn will encourage health plans to compete on the basis of quality and cost, like the companies that want the investors' dollars.

Like the SEC, the health care commission should also delegate to an independent, private, nonprofit agency the power to create clear, across-the-board measurement principles for determining the price and quality of care (the SEC assigns this role to the Financial Accounting Standards Board, or FASB). Independent professionals, bound like financial accountants by legal liability for misstatement and full disclosure, would

render opinions on the quality of information provided. And, like the SEC, the health care commission could be armed with powerful penalties for undercapitalization and misleading or fraudulent market behavior.

Why is a regulatory model for the capital markets a good model for health care? Because in both markets, consumers can purchase what they want directly, from a broker or health care provider, or indirectly, through a mutual fund or employer plan. In both, they require protection from unscrupulous firms. And, in both, they need reliable information to make intelligent decisions. Last, both the securities and the health care markets are complex and deal in probabilities based on past performance. There is no infallible way to predict how a particular investment or a particular health care decision will come out.

The U.S. securities markets are successful in ways that health insurance markets should replicate:

- Prices are fair in that they reflect all publicly available information.
- Buyers use this information to reward productive firms and penalize unproductive ones.
- Information and competition continually reduce transaction costs.

If these characteristics existed in the health insurance market, "bad buy" insurers would be forced to improve or wither. The "good buy" insurers would flourish. For example, when New York

state required the collection and dissemination of risk-adjusted mortality rates for hospitals and surgeons for coronary bypass surgeries, statewide mortality rates dropped, and the market share of "good" providers increased substantially.

Like cost-effective securities brokers, cost-effective purveyors of health insurance would be rewarded. Ameritrade, for example, openly compares its transaction costs with those of other brokers, spurring a competition to lower brokers' fees. In health care, some insurers would offer only low prices, while others would provide other services, such as extensive research and analysis of various approaches to health care, to justify a higher price.

By providing a level playing field, the SEC is critical to the efficiency of the securities markets. It has the power to enforce "truth in securities" and to regulate the trading of securities in markets through brokers and exchanges. Firms that trade their securities in interstate markets must register with the SEC and file regular information reports. Exchanges and interstate brokers must also register. The SEC reviews the rules for market operations and requires that brokers meet minimum capital requirements and submit information about their transactions. And the agency protects investors against deceptive practices.

Investors in health care — buyers of health insurance — also need these protections, and they need reliable information. In the securities markets, information reliability stems from the delicately balanced interaction among three private sector groups: the firms that offer securities, the FASB that sets standards of measurement, and the accounting profession.

The presence of these three groups creates checks and balances and fuller



CHAOTIC MARKETS: Consumers have faith in them because regulators guarantee transparency.

Health care consumers need specific, timely information to readily identify the health professionals who can best treat them, just as investors can choose from hundreds of excellent sources of information.

consideration of diverse points of view. Unlike a government agency, this troika does not sing out of one hymnal. And their private-sector nature requires political and financial support for their continued existence.

The key to achieving these desirable characteristics in the health insurance market is legislation that replicates these essential elements of the SEC model:

- A SEC-type health care commission should oversee the integrity of the process by requiring insurers to register and report fairly on their activities.
- The commission should delegate developing measurement standards for quality and cost to a private group like FASB and auditing to private

health care auditors.

- The commission should require public dissemination of all relevant information on cost and quality.

The much-abused American consumers of health care want and need government protection. The type that the SEC achieved in the securities markets will serve them best.

Regina E. Herzlinger, a professor at the Harvard Business School, is an expert in both health care and accounting. Her current events bestseller, Market-Driven Health Care (Boston: Perseus Books), won the 1998 Book of the Year Award from the American College of Healthcare Executives.

Getting on the *fast track* to universal coverage

We need to leapfrog the left-right political debate and require everyone to acquire health insurance — with tax credits and other reforms

by David Kendall

America's health care system today is notable for two dominant but clashing features. The first is that in the past ten years, managed care, the system everyone loves to hate, has successfully broken the back of medical inflation — at least temporarily. The second is that despite this accomplishment, a huge portion of our population, 44 million people, are still without health insurance. Worse, the numbers of the uninsured are growing despite a robust economy. Our challenge today is to achieve universal coverage and end this incongruity.

That managed care is under attack is apparent to everyone who has heard of the patients' bill of rights. That the pendulum of power in health care should now shift away from the insurers to the consumers (but not back to the health care providers) is forcefully argued elsewhere in this magazine. A parallel imperative, however, is that we cover the uninsured who not only suffer from their lack of coverage but also place a financial and a public health burden on the rest of the nation. We must achieve universal coverage, and do it soon. In the first place, it is morally and socially right. But, in addition, it serves the interests of those who are insured and paying their rightful share — often more than their rightful share — for our national fiscal and physical health.

What is the fastest and best route to universal health care coverage? We need to leapfrog the historic left-right political debates over fairness and find a Third Way that combines the progressive goal of full coverage with the efficiency of the private market place. Rather than neglecting the uninsured as the right has done, or pursuing a single-payer government plan that the left prefers, we need to use market competition, government rulemaking, and our tax system to create an environment in which self-interest and goodwill can lead to broader coverage and a healthier nation.

The three key tools to achieving universal coverage are health insurance tax credits, state reforms to expand coverage and choice, and a legal requirement that all Americans have health insurance.

Health Insurance Tax Credits

Because doctors, hospitals, and insurance companies are most responsive to the people who pay them, it is important to empower consumers to become their own purchasers of health care coverage. To encourage the development of an insurance market that is oriented to individuals, not just to employers, we should create a new government incentive: a refundable health insurance tax credit directed toward individuals instead of employers. Such

David Kendall is the senior health policy analyst at the Progressive Policy Institute.



Most of the uninsured work, but the self-employed and independent contractors — like taxi drivers — have little access to group purchasing power.

The GOP approach to reform

by David Kendall



Why Medical Savings Accounts don't do the job

Republicans often talk about empowering consumers, but their favorite program — the creation of Medical Savings Accounts (MSAs)—is at best a diversion from real consumer power and may even be harmful.

MSAs are tax-free savings accounts for health care expenses paid directly by consumers. They are coupled to a high deductible (e.g., \$3,000) insurance policy for very expensive health care problems. The idea is to encourage people to pay out of their own pockets for a larger share of their health costs instead of using the insurer as a middleman.

While involving people more directly in buying their own health care is a worthy goal, MSAs don't do much to empower consumers; they still leave employers in charge of health benefits. An MSA must be set up by the employer before workers can choose to use it. Moreover, the employer also chooses the insurance company. To truly shift power to consumers, choosing one's insurance company is much more important than choosing how much to pay out-of-pocket for health care.

MSAs have other problems. For instance, a tax deduction for MSAs takes potential funding away from tax credits for the uninsured and for people unhappy with their job-based coverage. In addition, MSAs, like any tax deduction, go disproportionately to the wealthy who are in higher tax brackets. Finally, if MSAs were broadly adopted, lower-income people with chronic conditions might be worse off financially because they would deplete their MSAs year after year and never have enough to cover the high deductible.

Ultimately, the debate about MSAs may be moot because they have proven far more popular among conservative politicians than in the actual marketplace. Since their enactment in 1996, fewer than 100,000 MSAs have been set up even though the law permits up to 750,000. A differently designed program might prove to be more popular, but Congress should not expand the program unless these problems are solved.

"While involving people more directly in buying their own health-care is a worthy goal, MSAs don't do much to empower consumers; they still leave employers in charge of health benefits."

an inducement would level the playing field for workers without coverage, while giving those who already have coverage more choices.

Until now, tax breaks for buying health coverage have been channeled mainly through employers, who pay for insurance on behalf of their employees. Employees receive this nearly invisible tax break because the cost of health insurance is not treated as income and thus not taxed. Yet the tax break for job-based coverage has one very important and interesting virtue. It induces people to acquire insurance who think they don't really need it, can't afford it, or are young and plan to live forever.

A universal, refundable tax credit would provide everyone with a better inducement by giving individuals an incentive to buy coverage even when they are healthy, just as people working for employers do. A tax credit controlled by individuals would help everyone who wants to buy coverage outside of their jobs and give them access to large purchasing pools that are independent of the workplace (see "Tax Credits" sidebar). That's why presidential candidate Bill Bradley has proposed letting everyone join the Federal Employees Health Benefits Plan, which offers up to 20 choices of private insurance plans to federal employees. In a similar vein, Vice President Al Gore would encourage small businesses to form and join local purchasing groups that could offer their employees more choices at lower prices.

As in every other sector of the economy, the key to expanding health care resources is to increase health care productivity. If the uninsured were insured, every dollar now spent on health care would produce better health care for everyone. But tax credits do pose one big problem: how much a tax credit should be worth. Should it be the same for everyone or should it vary? Should it be linked to income, gender, actuarial tables, or the health needs of various age groups?

It might seem fair to give everyone the same amount. But health insurance generally costs more when you are older or less

healthy because you have a higher risk of needing costly care. In addition, the poor need a bigger subsidy than everyone else to afford adequate coverage.

Ideally, a tax credit should be customized to each person's circumstances. A blue collar worker with a chronic disease who has to pay more for coverage but has fewer resources should receive a bigger tax credit. But there's another problem: Each state has its own rules on how much insurance premiums may vary for each person. New York, for example, allows no variation; this is called community rating. In states with community rating, a customized tax credit makes no sense. Congress could, of course, try to force all the states to use the same set of insurance rules, but it would face stiff opposition from the nation's governors and state legislators.

If King Solomon were faced with these problems, he might be tempted to give up. But here's one way to split the baby: a federal tax credit for a portion of the cost of insurance and additional grants to states to reconcile the value of the tax credits with the pricing of insurance. This approach is similar to Vice President Gore's proposal (see "Gore-Bradley Sidebar," p. 30). In contrast, Senator Bradley would set the value of his tax credit nationally and cut out the states' role in resolving this complex issue.

Paying for tax credits and grants will be a big challenge, too. But the cost is uncertain. No one knows how many of the uninsured will take advantage of the new program. Nor is it clear how much of their current health care costs — paid through public hospitals and emergency rooms, for example — would vanish from the public books through new coverage. Nonetheless, a reasonable starting point for covering the uninsured would be \$25 billion each year — a figure that falls between the differing amounts that Gore and Bradley have proposed to spend on the uninsured. As uncertain and as expensive as this sum may be, it is a commitment we must be prepared to make for the urgent goal of universal coverage.

Tax credits are not the only health policy idea for empowering consumers. Republicans

are fond of touting a program called Medical Savings Accounts (MSAs). But unlike tax credits, MSAs do little to make coverage more affordable or to let people make insurance choices independent of their jobs.

In contrast to MSAs, the tax credit proposal already has a broad political following. It has won support from the ultimate congressional odd couple: House Majority Leader Richard Arney (R-TX), a conservative, and Rep. Pete Stark (D-CA), a liberal and supporter of a Canadian-style, single-payer health care system. With such appeal, it can be enacted and implemented expeditiously.

State Reforms to Expand Coverage and Choice

The states need to be full partners in the creation of a consumer-empowered health system. They control many of the levers to expand coverage and choices after the federal government has leveled the playing field in the tax code between job-based coverage and individually purchased coverage.

Additional grants to states to supplement the federal tax subsidies would let Congress

"If the uninsured were insured, every dollar now spent on health care would produce better health care for everyone."

How would a health insurance tax credit work?

Tax credits reduce the amount of income tax a person pays. It is an absolute dollar amount that comes right off the top of a person's tax bill. In contrast, a tax deduction reduces the amount of income that is taxed. A dollar used as a tax credit is therefore worth more than a dollar used as tax deduction, and the value of a tax credit does not depend on your tax bracket. For most people, a health insurance tax credit would lower the amount of tax withheld from every paycheck, reducing their annual income tax bill.

For those who earn too little to owe income taxes, the government would provide a refundable tax credit to offset the cost of purchasing health insurance. Making the tax credit refundable would still leave some people with the problem of paying for the coverage before they got the credit. That's why Sen. Bill Bradley has proposed letting the credit go directly to the insurance company and be applied against the taxes they owe. Individuals would merely have to show on their tax return that they were eligible to use the credit.

What Works/Pooling resources for the poor

Dr. Susan Landis puts it all together in North Carolina / by Fran Carlson

The experience of one Appalachian community — and the efforts of a determined doctor — can be instructive in finding a way to keep America's low-income population healthy.

In Buncombe County, North Carolina — the mountains and valleys surrounding Asheville — Dr. Suzanne Landis has helped devise a physician-led program of regular health care for an indigent population that has for too long been dependent on emergency rooms for desperate solutions to otherwise routine health care problems. Despite a general backlash in the managed care era against charity care, Landis — a relentless crusader — has persuaded 80 percent of the county's physicians to join Project Access, which offers free and regular care to those who need it. Physicians have agreed to volunteer eight days per year in a community clinic or to see patients in their private offices. Each primary care physician takes on 10 patients per year, each specialist handles 20. In addition, three local hospitals have donated in excess of \$4 million in free services. So far, 13,000 low-income people have been served by the program.

"Patients have different portals of entry for care," says Alan McKenzie, executive director of the Buncombe County Medical Society. "They may visit our urgent care center, one of four free clinics, be referred by a physician, or a social service agency."

The results are seen in the improved general health of the population. One four-year study showed that area hospitals are spending 25 percent less on charity care, now that it is routinized, than before, when it was often an emergency. Both hospitals and physicians are now seeing twice as many indigent care patients and the dollar value of charity care provided by physicians has increased from \$1.8 million in 1997 to \$3 million in 1999.

The most surprising success of Landis's crusade was the recruitment of local pharmacists into Project Access. Obtaining affordable medications is one of the major stumbling blocks even in the best charity care plans for the uninsured.

Under Project Access, the patients carry a medication card like any other health insurance card. Participating pharmacists then provide medication, on average, at wholesale minus ten percent. The patient pays a flat \$4 co-payment and the Buncombe County Health Department assumes the rest of the cost with monies that formerly would have flowed to hospitals as reimbursement for indigent care.

A six-month follow-up study shows that at the time of enrollment 39.2 percent of the patient population was employed. After six months 51 percent of all the participants in the sample were working, and of those who had left the program (presumably for reasons of increased income or employee insurance eligibility) 52.4 percent were working. Health outcomes in the same study show that over 80 percent of the patients believed their health to be "better" (13 percent) or "much better" (69 percent).

"The best outcome for me is a note from a patient telling me that they are now able to return to work," says Landis, whose Mountain Area Family Practice is also part of Project Access. Landis's interest in finding regular care for underserved patients on fixed incomes developed in part during her work with the county health department in Palm Beach County,



Dr. Susan Landis: "The best outcome is a note from a patient that they are now able to return to work."

Florida. There, most physicians did not accept Medicare assignment. Landis began thinking about the importance of community-wide systems of caring for the medically indigent. "I had money to provide care, but no mentors who thought more broadly than one patient at a time. My experience taught me that physicians have a responsibility to improve the health of the whole community, including the uninsured and the underinsured."

Landis took these insights with her to get a public health degree from the University of North Carolina on a Robert Wood Johnson Clinical Fellows scholarship. After moving to Buncombe County, she obtained a \$100,000 Reach Out America grant from the Johnson Foundation for community assessment. That in turn was parlayed into a three-year implementation grant of \$200,000, the equivalent of one month of free physician care by members of the Medical Society. As a result of her success, Landis and Alan McKenzie are now teaching other communities how to equitably reallocate their resources to bolster the tradition of physician-led charity care and give needed assistance to the uninsured.

Fran Carlson is a freelance writer from Lafayette Hill, Pa.

nudge the states to provide more coverage and choice. By combining the new funds with the programs they already control, like Medicaid, the Children's Health Insurance Program (CHIP), and insurance regulations, the states can expand coverage in new and creative ways. Only a few states like Wisconsin have taken advantage of the flexibility that current federal programs allow for blending disparate funding sources and providing a variety of choices (see "BadgerCare," p. 35).

The amount of these new grants would be tied to each state's actual performance in reducing the number of uninsured and providing access to health care services. Vice President Gore has proposed a similar guideline, but it applies only to the CHIP program for children. If he expanded it to include Medicaid, then Gore would also push Medicaid toward the economic mainstream. His plan would then approximate what Bradley has proposed to do directly: give every Medicaid beneficiary a voucher equal to the value of coverage and the opportunity to buy into the Federal Employees Health Benefits Program.

With such incentives in place, states would be smart to aim at getting the biggest bang for the buck by using choice and competition to restrain prices. To achieve equity, they could also adjust subsidies by income and health risk. They should re-examine community rating laws that have the perverse effect of forcing young, healthy people to subsidize older, wealthier people, thus driving the younger citizens into the ranks of the uninsured. Finally, they should try to lower transaction costs for buying coverage and making choices by promoting online systems for selecting and paying insurance companies.

A Requirement to Have Insurance

Better incentives through tax credits and state grants won't ensure that everyone buys coverage, but those who don't will not get much sympathy. These "stay-outs" are either too well-off to qualify for financial assistance or they simply do not believe they need coverage. Either way, they become a burden on the system, an extra cost to

taxpayers, as soon as they need health care they cannot pay for. They become "free riders." It is clearly in the interests of those with coverage to require that the remaining uninsured get coverage. If everyone were insured, the free riders would pay, and our tax dollars would be spent on much more efficient forms of health care than visits to an emergency room.

Compelling everyone to have insurance on their health so they cannot become a forced burden on everyone else is no different from requiring everyone to have liability insurance on their cars so they cannot do harm to others without paying for it. Failure to get coverage, and certify it on tax returns, should be penalized with a tax surcharge. Free riders need to be sent a clear message about their responsibilities rather than use the excuse that they are deserving of help. They should pay the price when they impose on the rest of us their bills for costly care.

Bill Bradley has clearly defined the responsibility of parents to cover their children with a combination of increased subsidies for children's coverage and a requirement that all parents insure their offspring. This approach also demonstrates that the three steps outlined here — tax credits, grants, and a free-rider tax — do not have to occur sequentially or for the whole population in one fell swoop. In the same way, Vice President Gore's plan can and should be adapted to require all parents to cover their children and to prepare for the day when it is politically feasible to mandate that everyone have coverage.

In the United States, progressive action must bind together the interests of the middle class and those who are struggling to get there: the insurance haves and have-nots. A strategy to increase coverage among the uninsured and choice among the insured may offer the most realistic chance that our nation has ever had for achieving universal coverage and informed consumer empowerment. A policy based on both self-interest and goodwill that mandates coverage for our entire population, supported by tax credits and state grants, is an approach that can succeed politically and fiscally. ■

"Compelling everyone to have health insurance is no different from requiring everyone to have liability insurance on their cars."

Gore vs. Bradley

As the race for the Democratic presidential nomination has heated up, it's no surprise that health care has quickly risen to the top of the agenda. What is striking, however, is how far the proposals of Vice President Al Gore and former Senator Bill Bradley have come from the old Democratic dream of a government-run insurance scheme.

While there are some important differences in their plans and lively debate over how fast, how deep, and how broad health care reform should be, the truth is that both candidates have adopted the New Democrat position of public financing for private insurance. Both have rejected a government-run system. Both would stimulate competition to restrain costs, use the government to make coverage available and affordable, and give individuals and families the final responsibility to choose their health insurance.

Through new tax credits, the Gore and Bradley proposals would give more people an equal opportunity to purchase insurance. Both candidates encourage people to purchase coverage through the Federal Employees Health Benefits (FEHB) program or other purchasing groups. The Bradley proposal would eliminate the Balkanized bureaucracies currently delivering health insurance to the poor. The Gore proposal focuses instead on making the current system more accountable. All of their main ideas reflect longstanding New Democrat themes. For all these commonalities, however, there are some key differences in the two candidates' proposals.



Gore's Plan

- Grants a refundable tax credit for one-fourth the cost of insurance for individuals who purchase coverage on their own and a similar 25 percent tax credit for small businesses that offer their employees new health plan choices through purchasing coalitions (supermarkets for health insurance).
- Funds coverage for children through the Children's Health Insurance Program (CHIP) up to two and one-half times the poverty rate and for their parents up to the level set by each state.
- Holds states accountable for using CHIP funds effectively by setting enrollment targets, bonuses, and penalties.



Bradley's Plan

- Creates a refundable tax credit for coverage of children in families with incomes up to twice the poverty level and for adults up to the poverty level. (A reduced credit would apply for children between two and three times the poverty level and for adults between the poverty line and twice the poverty level.) Families would be required to get coverage for their children.
- Allows all Americans the opportunity to buy coverage through the Federal Employees Health Benefits program.
- Splits Medicaid to give the federal government responsibility for health care coverage and the states responsibility for long-term care.

How they would cover the uninsured

by David Kendall and Jeff Lemieux—Progressive Policy Institute

Pros and cons

By any measure, Bradley's plan would be more expensive but also more likely to achieve near-universal coverage. Bradley's generous tax credits, which would replace the state-run CHIP program and part of the Medicaid program, would provide a very strong incentive for the uninsured to purchase coverage. But the sweep and complexity of such a change would almost certainly meet with strong political resistance and prevent quick enactment of his plan.

The Gore proposal has a better chance of enactment. Bipartisan support in Congress has already formed behind legislation that mirrors Gore's individual tax credit plan. Furthermore, Gore's proposal to expand CHIP builds on a history of bipartisan cooperation. But fewer of the uninsured would be covered under Gore's plan because it uses a more bureaucratic system and because the combination of its tax credits and CHIP expansions are less generous than Bradley's tax credit.

To ensure fairness, both proposals would grant tax credits not only to uninsured families, but also to families that already purchase coverage. Bradley's proposal, with its large tax credits, would significantly hike the take-home pay of many lower-income families who currently struggle to afford health insurance. That extra fairness, however, raises the cost of Bradley's plan.

Both proposals also contain lesser planks. Gore has embraced the Clinton administration proposal that allows the near elderly to purchase coverage from Medicare. In the interest of treating everyone equally, Bradley even offers a tax deduction to affluent people who already have coverage. Despite the cost, neither of those ideas would significantly increase the number of people with coverage.

What about the cost?

Each candidate's campaign staff have suggested that Bradley's core tax credits would cost the federal government about \$40 billion to \$45 billion a year and that the cost of Gore's tax credits and CHIP expansions would be in the \$10 billion to \$12 billion range. Those amounts are highly uncertain, however. In both cases, the final cost will largely be determined by the number of people who choose to take advantage of the new opportunities for health coverage.

Although covering the uninsured through tax credits is expensive, it can actually reduce costs for those who already have insurance. That is because most of the uninsured are relatively young and healthy. Adding them to large group insurance pools will reduce the average premium for the group.

Finally, uninsured people usually get at least some treatments if they are ill or injured. The costs of that care are spread to government programs and to those with insurance, sometimes directly and sometimes in subtle ways. Therefore, reducing the number of uninsured will allow governments and insurers to reduce the portion of their payments that essentially subsidize hospitals and doctors for treating those who cannot pay.

Minnesota-based UnitedHealth Group is leading the way in reporting performance data. It is also eliminating the dread middle man — managed care bureaucrats — so doctors and patients can make medical decisions.

How well doctors communicate

Cost Group I \$

- Children's Physician Hospital Organization
- St. Croix Valley Healthcare
- Wright/Sherburne County Physicians Hospital Org.

Cost Group II \$\$

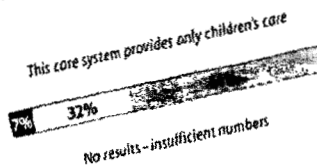
- Access Quality Care System
- Allina Care System
- Aspen
- Fairview Physician Associates
- Family Health Services Minnesota, P.A.
- HealthEast Care System
- Hennepin Faculty Associates
- Minnesota HealthCare Network
- North Physicians Health Organization
- Park Nicollet/Methodist/HealthSystem Minnesota

Cost Group III \$\$\$

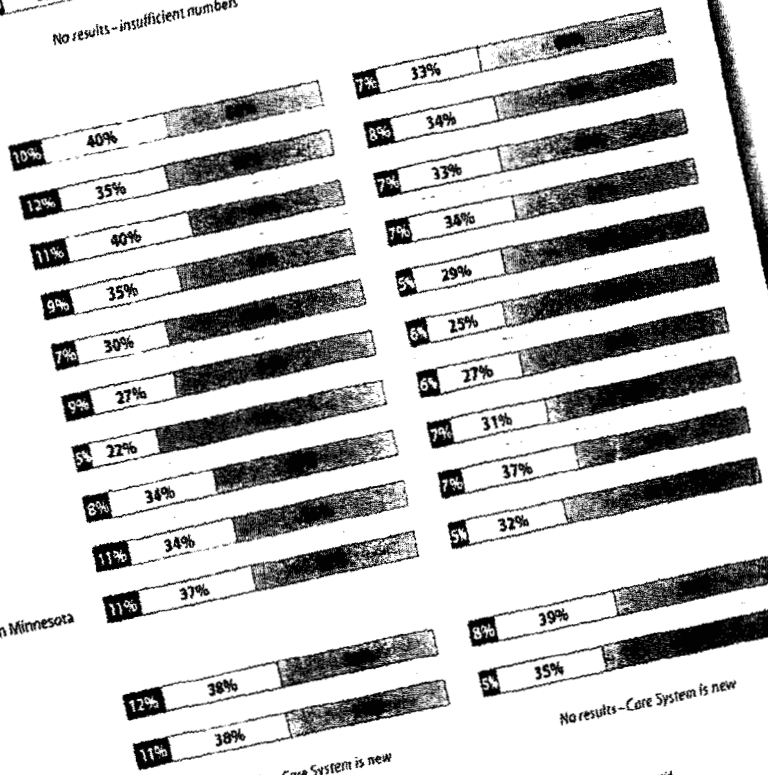
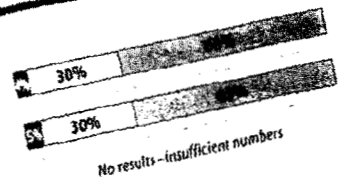
- HealthPartners Affiliated
- HealthPartners Medical Group
- University of Minnesota Physicians Care System

RATING PROVIDERS:
This page from the Choice Plus survey book helps consumers learn what their peers think of various medical practices in the area, divided into three price categories.

Adults' Care



Children's Care



Quality Award Winner
See page 6 for details about Choice Plus quality awards

Percentage who said their doctors sometimes or never communicated well
Percentage who said their doctors usually communicated well
Percentage who said their doctors communicated well
best survey results

Part II: Twin Cities Metro

Revolution in Minnesota

by Kerry Tremain

When America's second largest managed care company, the Minnesota-based UnitedHealth Group, announced last November that it would give doctors the final say in authorizing treatments, the news exploded in banner headlines. The loudest complaint about insurers from both doctors and patients — that care is often denied for purely financial reasons — was instantly solved, at least for those insured by UnitedHealth. The largest insurer, Aetna, quickly signaled that it wanted to follow suit.

Further, UnitedHealth announced that it would measure and publish quality data on provider performance, a giant step toward what experts call the next health care megatrend: consumer empowerment.

Consumer empowerment is also the theme of another less publicized but equally potent innovation from Minnesota, the Buyers Health Care Action Group (BHCAG). BHCAG (pronounced "bee-kag") is a coalition of the Twin Cities' biggest employers, including Honeywell, Pillsbury, and 3M, representing about 250,000 of the area's employees.

Since 1990, BHCAG has marshaled the collective clout of these employers to control spiraling health care costs and improve quality. "Patient/employee involvement, quality of care improvement, and increased efficiency are the major goals," explains Pat Drury, a health care consultant to the group.

Three years ago, BHCAG began a far-reaching experiment when it stopped buying group policies from large insurers like UnitedHealth. Instead, it began contracting directly with doctors and hospitals for its members, thus cutting out the middleman: the insurance companies. The new program, called Choice Plus, is already showing signs of accomplishing all of BHCAG's goals. Chief among these goals, made possible by eliminating the insurance company filter, is the ability to evaluate health care providers directly, based on cost and quality. More important, BHCAG passes its evaluations directly to its consumers.

Choice Plus offers a selection of care groups that are rated on cost (one, two, or three dollar signs), and quality (one, two, or three stars) — almost like a restaurant guide that uses stars or chefs' hats. In most cases, if an employee chooses a care group in the \$\$\$ category, he or she must pay extra (typically about \$500 a year) for the coverage. By referring to the BHCAG guide, employees can easily determine who is providing the best value and make decisions based on what quality of care they are getting for their money.

Another of BHCAG's key goals was to eliminate the insurance company practice of "cherry picking" — trying to sign up the young and the healthy and avoid the old and the ill. To accomplish this, Choice Plus adopted a risk adjustment formula that allows it to pay more to those care groups — hospitals or integrated physicians' practices — that see more sick people. This shifts care groups' incentive from competing for healthier people to more efficiently treating the patients they have. If they do improve care, the care group gets lower cost ratings and higher star ratings in the Choice Plus guide.

By making these dramatic changes, Choice Plus fundamentally challenges the managed care revolution of the 1990s led by health maintenance organizations (HMOs). Because HMOs typically collect insurance premiums from employers and negotiate contracts with integrated groups of primary care doctors, hospitals and specialists ("care groups"), most doctors and hospitals were forced to organize themselves into care groups to compete for HMO contracts. They could no longer just set their fees and charge employers whenever an employee needed care (the "fee-for-service" model). As HMOs grew in size through mergers and buyouts, they used their new power to force down care group prices, temporarily taming health care inflation.

Despite the power shift in favor of the insurers, HMOs and care groups remain defacto partners, and not necessarily on the patients' behalf. HMOs often sign up as many care groups as possible in order to offer employers more options.

Kerry Tremain is a writer and an editor of BLUEPRINT in Berkeley, Ca.

"As long as the care groups show that they are providing good quality care at a reasonable cost, the providers can set their fees at whatever level they like, rather than having them dictated by an HMO."

Care groups also typically sign up with as many HMOs as possible to expand their patient base. In Minneapolis/St. Paul, nearly every doctor in the region has had to join all three of the big HMOs to survive.

These amalgamations of care groups under multiple HMOs, however, hide from the health care consumer the two most essential pieces of market information: the quality and cost of specific caregivers. The HMOs have little incentive to monitor the long-term quality of care groups, especially if doing so upsets the providers. They are focused on short-term costs.

To limit costs, HMOs usually pay care groups an annual fee for each employee covered, regardless of how much care the employee requires during the year. This has led to cherry picking, with the result that HMOs and care groups typically compete less to provide more efficient care to sick people than to find people that don't need much care. Doctors and HMOs that take care of more sick people are penalized. And those that serve a healthier population rarely pass on their savings to the employers or consumers.

These incentives had the perverse effect of fueling consumer fears of managed care. People are afraid that they won't be able to get the coverage they need (many are forced to sign contracts excluding coverage for "prior conditions") and that their treatment will be shortchanged for financial reasons.

Because of BHCAG's risk adjustment model, care groups have been receptive to the program. As long as they can show they are providing good quality at a reasonable cost, the care providers can set their fees at whatever level they like, rather than having them dictated by an HMO. Some care groups have complained about the way risk adjustment is calculated, or the way quality is measured, but few have dropped out of the program.

It is too early to tell how successful Choice Plus will be, but the initial returns look promising. More employers and employees are signing up for the program, which has increased from 116,000 employee members in 1997 to 150,000 in 1998. And employees are starting to feel their buying power. On average,

fewer people enrolled with high cost care groups, except for the ones that also had high quality ratings. The four low-cost groups had increases of 15 percent to 57 percent. Care group bid prices also have risen more slowly than area HMO prices.

Hopes for the three-year-old experiment are high. Still, Choice Plus will have to grow in order to leverage greater change in the area's health care system. BHCAG currently represents less than 10 percent of the area employees and therefore a small percentage of each care group's practice. BHCAG's best hope is that the Minnesota state employees group, an associate member of the program with 150,000 employees, will soon adopt its model.

Some HMOs do see BHCAG as a threat. In a report on BHCAG, *Managed Care* magazine told its readers, many of whom are HMO executives, that in the worst case their companies "could be reduced to a service industry for providers and their employer customers." Of course, that is exactly what many health care reformers hope for. They see the UnitedHealth announcement as a step in that direction.

Managed Care reassured readers that "the consensus today, health plan executives will be relieved to know, is that that won't happen." Perhaps. But baby boomers, who have led a revolution in consumer-driven quality in everything from chocolates to computers, are growing older and using more health care.

And employers around the country are looking for ways they might replicate the BHCAG model if it is successful. Already one employer group in Iowa, Community Health Purchasing Corporation, has started a similar program.

Consumer empowerment reformers want experiments like Choice Plus to spread. If the trend catches on, it could finally reconfigure — and rebalance — the tilted power equation between patients, doctors, and insurers. Ellen O'Connor of the big business alliance, the Washington Business Group on Health, told *Fortune* that BHCAG "is probably the major health care experiment going on anywhere in the country. A lot of people are watching to see how this turns out." ■

What Works / Covering Wisconsin's poor

Badgercare insures poor children *and* their parents / by Margy Waller

Laura and Jim Zook have not been able to afford health insurance for most of their 23 years of marriage. As owners of a dry walling business in Almena, Wis., they struggle to live on an income from the business that last year was about \$20,000 — well below the official poverty level. As a consequence, difficult choices are made every day.

Because of complex federal eligibility standards, their children have been on and off the low-income health program for years. The confusing eligibility rules include income, value of the family car, and an arbitrary cut-off age of six for children in families with slightly higher incomes.

"When you don't have insurance, you don't take care of your health unless it's an emergency," says Laura Zook. "And when it's an emergency, you can't decide not to take care of it."

Just such an emergency occurred in 1998 when their teenage daughter Janelle, who was too old for the state insurance program, had an emergency appendectomy. The Zooks ended up with a \$6,000 hospital debt.

Since 1999, it has been a different story for poor working families like the Zooks in Wisconsin. Now, they are eligible for the state's innovatively designed health insurance program called BadgerCare. The name was chosen to differentiate the new program from traditional welfare — and because the Badger is the state's mascot.

"People don't care what the program is called, they just want health care," says program administrator Angie Dombrowicki.

BadgerCare kept the Zook family off welfare last year. Jim hurt his back and needed medical treatment; without it, he could not put up dry wall. With BadgerCare, Jim was treated and kept working.

BadgerCare is unique among the state-designed and publicly-funded health

insurance programs. For one thing, it covers children *and* their parents — not just the children. This makes the Wisconsin program exceptional; even with flexibility provided in the welfare law and the new federal Children's Health Insurance Program (CHIP), most states still follow the arbitrariness of the old federal rules. These rules often prevent children in the same family from having the same coverage, and programs almost never include working parents.

In addition, the Wisconsin program serves all low-income families in the same way. Uninsured families with income below 185% of the federal poverty level (\$30,895 for a family of four) are eligible regardless of whether they were recently on welfare. Many other states operate differently, providing different insurance coverage to families leaving welfare than to other working poor families.

By embracing flexibility and equity, Wisconsin has created a national model for working family coverage. In fact, President Clinton has just proposed a new FamilyCare program to cover the parents of children eligible for Medicaid or CHIP. (Its name is even similar to BadgerCare's.)

Despite this innovation in program design, Wisconsin still faces a health insurance problem: making sure all eligible families enroll.

The state had the highest reduction in Medicaid enrollment of any state between 1995 and 1997: 19 percent; nationally the reduction was 7.4 percent. While Wisconsin's Medicaid decline coincided with significant welfare caseload reduction, the cause is the subject of in-state debate. Advocates and some Democratic legislators think the state has failed to ensure welfare leavers get the ongoing coverage they should, while the Thompson administration says it has

resolved problems with maintaining coverage for those who leave welfare.

Evidence of the unresolved debate is found in last year's budget deliberations. The Wisconsin legislature included proposals to enhance outreach and ease enrollment in Medicaid and BadgerCare. But, Governor Tommy Thompson vetoed them, saying some of the provisions were unnecessary because the administration was already taking similar action. He cut one proposal because he thought it would add enrollees, resulting in additional state expenditures.

Some advocates and academics are concerned that the poorest families who remain eligible for Medicaid may not be getting benefits. "Because BadgerCare and Medicaid are so intertwined, the state's reluctance to do aggressive outreach for BadgerCare hurts efforts to get everybody enrolled in Medicaid who is eligible," said Anne Arnesen, Executive Director of the Wisconsin Council on Children and Families.

John Pawasarat, Director of the University of Wisconsin-Milwaukee's Employment and Training Institute says, "So far, the state has focused on extending BadgerCare to members of a family with partial subsidized insurance coverage. Most of these families have a recent connection to welfare. There doesn't seem to be much outreach to other working poor families yet."

Wisconsin is a model for health insurance program design, but an unfinished story on the outreach and enrollment side. It will be too bad if one of the most ingenious uses of the Medicaid and CHIP flexibility — which Governor Thompson demanded and got — falls short of its potential to support working families.

Margy Waller is senior fellow for social policy at the Progressive Policy Institute.



2001: A personal health space odyssey

Store your health records. Talk to your doctor. Fill a prescription.
All online and free, say boosters. But serious privacy issues must still be resolved.

by Katie Donohue



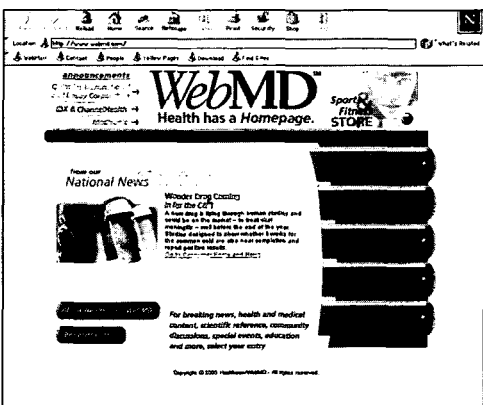
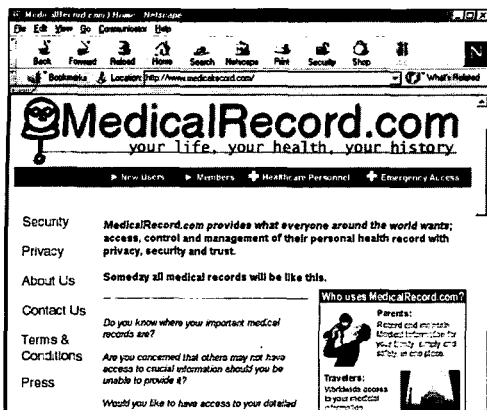
It's 7:30 Monday morning, December 10, 2001. Reaching for your coffee, you log on to the Internet to check yesterday's box scores and a few of your stocks before starting work. Just then, a health alert from your support group for cancer survivors flashes across the screen. Curious, you click on the icon for your personal health space. You learn of a new screening test that may detect cancer relapses earlier than before.

Your instant message board is buzzing with debate among members of the support group about the pros and cons of the new test. An e-mail arrives from your family doctor, who has reviewed the clinical trial for the test and then searched his patients' medical records over the Internet to identify those who might benefit from the screening. He recommends that you see a cancer specialist to have the test performed. You surf to your health plan's Web site and check the list of cancer specialists available through the plan. After reviewing their performance profiles, you select a specialist, book the appointment online, and give the specialist the password to your electronic medical record so she can review your chart before the appointment.

Science fiction? Hardly. Many of the elements in this scenario already are available online, but they have not yet been linked together in a centralized, interactive personal health space.

SURFING FOR HEALTH: Millions of Americans already look to the Internet for medical information. But is it reliable?

Katie Donohue is a free-lance writer and student at the Medical College of Virginia.



TWO EARLY BIRDS: MedicalRecord.com and WebMD. Rupert Murdoch put \$100 million into the latter, owned by Healtheon.

Tom Munnecke, a consultant to the Department of Veterans Affairs, coined the term “personal health space” to define the concept of using the Internet to manage health information. And such personal health spaces could become available and popular rapidly. A recent Harris Poll showed that 74 percent of Internet users have looked for health information.

New sites appear every day to meet that demand, and Wall Street has taken notice. One of the most prominent is WebMD, now owned by Healtheon, the Internet company founded in 1996 by Silicon Valley entrepreneur Jim Clark, the co-founder of Netscape. WebMD seeks to connect consumers, physicians, insurers and other participants in the health care system. By late 1999, Healtheon had attracted a \$100 million investment from media mogul Rupert Murdoch. Showing its ambition to bring millions of consumers into its new online health care service, WebMD surprised viewers of the Super Bowl last January with a striking set of television ads featuring Muhammad Ali (see p. 40).

Yet even as the online health sites grow and proliferate, serious concerns have been raised about the issue that may be most important to potential users: the security and privacy of their personal health information. “Trust is critical,” says Munnecke, if consumers are to feel safe managing their personal health data online.

WebMD and another leading site, MedicalRecord.com, say they employ tight security for information that might identify a specific person. But both companies reserve the right to assemble health records without personal identifiers (“aggregate information”) into large databases that they then provide to vendors — without specifically notifying users that they have done so. MedicalRecord.com includes a warning that it may collect non-identifying patient data and give “relevant patient-oriented statistical information to healthcare providers, payers,

drug and medical device companies and clinical care facilities.” WebMD displays a similar notice and cites examples, telling users that it may report to a pharmaceutical company that “25 percent of our users have tried alternative medicine” or “30 percent of our users live east of the Mississippi.”

Despite these disclosures, however, a recent study suggests that some online companies may have been sharing personal health data with other businesses, such as advertisers, in ways unknown to their users (see “Is your personal health information really safe?” p. 40).

The debate over health privacy is intensifying just as some health Web sites are beginning ambitious advertising campaigns to draw consumers to their sites, such as WebMD’s Super Bowl ads. And consumers are coming: the online health services are growing in both variety and number at a breathtaking pace. MedicalRecord.com and WebMD attract consumers by allowing them to store their medical records online for free. MedicalRecord.com assists users in selecting a password and guides them through a series of questions to establish their medical history.

“Most medical records are scattered around the country as patients move, switch healthcare providers, or insurance plans,” says G. Edward Kriese, the company’s president and CEO. “Through MedicalRecord.com, people are able to manage their own and their family’s medical history... Their records are in one place, they know they’re current, and they now have control over who is accessing their information.” If they wish, users can grant doctors access and carry their passwords on wallet cards in case of emergency.

“The advent of online medical record management is especially useful during emergencies,” says Peter Alan Hudson, MD, a San Francisco Bay-area emergency room physician. “Regardless of a patient’s location, the medical records will always be accessible — even if the primary care physician is not.”

In addition to storing medical records, WebMD allows members to participate in online chat rooms and support groups. Members can elect to receive e-newsletters on topics ranging from diabetes to depression.

Another company, the Institute for Healthcare Improvement, has launched a pilot project called “Idealized Design of Clinical Office Practices.” One component of the program uses a computer-based registry to link patient medical records and track key health indicators. After

(continued on p. 42)

“Online medical record management is especially useful during emergencies,” says one ER doctor.

“The medical records will always be accessible — even if the primary care physician is not.”

What Works/Making consumers partners

Fresh from Idaho: self-care online / Interview by Marilyn Snell

What happens when patients become partners in their health care rather than merely passive recipients? According to Donald Kemper, quality of care goes up and health costs go down. The harmful effects of medical errors can also be reduced. For 25 years, Kemper, founder and CEO of the nonprofit health education organization Healthwise, has been testing his thesis. Based in Boise, Idaho, Healthwise provides self-care information to eight of the 10 largest managed care organizations in the country, as well as to employers, hospitals, and medical Web sites.

In 1970, when I was a lieutenant in the U.S. Public Health Service, I attended a talk by Assistant Surgeon General Vern Wilson. He said that the greatest untapped resource in health care was the consumer. This was a radical idea then.

The following year, the federal government selected 19 communities across the country to do innovative things in health care, and one of those communities was Boise, Idaho. They hired me to come here and help rock the boat. And I got to try tapping into the health care consumer as a resource. We asked people what information would be most helpful. What we got back were some very common sense things: tell us what we can do ourselves versus what we have to see the doctor for; help us prepare for doctor visits so that we'll get our money's worth; tell us where we can get good information so we can make better decisions. These kinds of basic inquiries directed the formation of Healthwise in 1975.

Today, Healthwise's research librarians find the best studies on health issues. Then our team of writers and physicians put that powerful information into consumer-friendly terms. We then have a group of 65 national experts representing each area of medicine review the

information and make certain that it's accurate, appropriate, and effective for people to use in making important decisions. Finally, we put this information into books and also into electronic form for use on Web sites, in nurse call centers, or in other local area networks.

Colds, flu, simple backaches, etc., are health issues that often take care of themselves if you just wait long enough. These kinds of "time-limited acute symptom illnesses" account for about 20 percent of doctor visits. With support, patients can monitor and take care of most of these problems themselves. The trick then is knowing when a particular problem exceeds their ability to deal with it — when symptoms become more complicated or progress to a level requiring professional help. Our books and Web sites give people that guidance.

Health care is improved when patients and physicians become partners. By giving patients prescription-strength information, they can speak the same language as their doctors. They can say, "I've reviewed the guidelines, doctor, and I'm not sure I'm ready for bypass surgery. What do you think?" Then, together they can work through the literature to reach a shared decision.

Currently, there are 25,000 Internet sites from which you can download health information. If you pick the wrong bit of information, it can literally be bad for your health. And physicians are concerned and frustrated when their



DON KEMPER OF HEALTHWISE: "There are 25,000 sites from which you can download information. If you pick the wrong bit, it can be bad for your health."

patients come in with an inch-thick stack of downloads from the Internet. To help physicians deal with this kind of information glut, Healthwise has created an evidence-based Internet "Knowledgebase" so that the physician can actually prescribe information to his or her patient. It actually helps the early part of the visit go quickly because the Knowledgebase helps the patient prepare so they can describe their symptoms accurately to the physician. And then they have more time at the end of the visit to really discuss what they do at home, what the treatment options are, etc. High-quality care is not always getting the most care — it's getting the care you need.

Marilyn Snell is a free-lance writer based in San Francisco.

Is your personal health

Why the online industry must provide tighter safeguards.

To people considering the use of an online health site, privacy and security are the paramount issues. After all, personal medical data is far more sensitive than a credit card number.

Consumers showed their concern in a survey conducted this winter by Cyber Dialogue for the California Healthcare Foundation. Seventy-five percent said they are worried about the transfer of personal information from health Web sites to third parties such as advertisers. Another 60 percent expressed concerns that a hacker might access their personal health data.

Yet the survey also found that if privacy is assured, consumers are willing to share personal information in exchange for health services. But they are divided on who should protect their private data. Twenty percent said industry associations should be play that role, compared to 35 percent who chose government. This puts policymakers in a difficult position when it comes to protecting consumer privacy while allowing health Web sites the

freedom they need to succeed.

The release of the survey this winter, in combination with a study conducted by researchers from Georgetown University's Health Privacy Project, caused a firestorm in the online health field. It illustrates how the industry is turning to self-regulation to maintain consumer trust and avoid government regulation.

The Georgetown researchers traced the flow of information among consumers, advertising companies, and health sites such as Drkoop.com and WebMD. The team then compared health sites' privacy policies with their software code and uncovered significant inconsistencies. It charged that several prominent sites were collecting personal information about their users and sharing it with advertising companies without notifying consumers in the privacy statement.

"The study authors didn't think we provided enough information in our privacy policy statement," said Charles Saunders, MD, chief medical officer of Healtheon/WebMD. "They implied



ME.
FIGHTING TIME



TIME WASTED IN HEALTHCARE

information really safe?

that...personal information leaks out." Saunders said that the only information WebMD shares with advertisers is the number of people who view an ad and the number of people who click on it.

Several of the sites targeted in the study have contracts with a privacy watchdog group known as TRUSTe to monitor their privacy practices. To display the TRUSTe seal of approval, Web sites must post a privacy policy that discloses when and how information is collected. They must also allow consumers to choose whether or not that information will be shared with third parties. TRUSTe audits sites every year before renewing their contracts to ensure that privacy policies are consistent with business practices. Consumers can also file complaints with TRUSTe.

Dave Steer, a spokesperson for TRUSTe, said nine of the health sites examined by the study have contracted with TRUSTe. He said the study found that seven of those health sites "are not compliant with their own privacy policy."

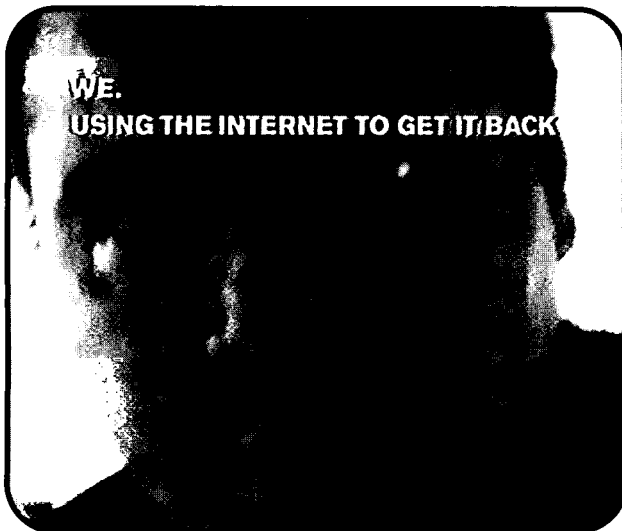
In February, TRUSTe said it planned to send an alert to more than a thousand of its member sites, reminding them of the importance of disclosing data-sharing practices to consumers. TRUSTe has also begun working with the health sites found to be violating their privacy statements to ensure future compliance. "This study arms us with the information we need. If Web sites don't comply, we can revoke their seal or we can take them to court for breach of contract," Steer said.

In response to the study, WebMD plans to display its privacy policy more prominently on its site, so that users do not have to click through multiple pages to reach it. "We intend to beef up the amount of information and the directness with which we communicate the details of our policy," Saunders said.

The road to an online health world has hit one of its bumps. How the industry responds will determine how quickly consumers feel their privacy is guaranteed enough to put their personal information in cyberspace.

—Katie Donohue

REACHING FOR THE STARS: WebMD jumped into bigtime marketing with a series of Super Bowl television ads featuring Muhammad Ali. The ads were confusing to some but seemed a direct challenge to the traditional off-line health care system. Yet even as online health companies reach for new markets, concerns persist about privacy and security problems on some sites.



learning about a new drug or treatment, doctors can quickly search the computer database for patients who might benefit. Doctors who rely exclusively on paper records would have to read every patient's record individually to provide the same quality of care.



RECORDS FOR LIFE: Online data can track a person's health from cradle to grave.

"Current laws concerning medical records are more suited for the Stone Age than the Information Age."

"It gives us an opportunity to provide more proactive care to chronic disease patients. It is a much more prevention-based model," said Mora Babineau, project manager.

Collections of online medical records could also improve care for populations of patients by pooling epidemiological data on a scale that would be impossibly slow and expensive with paper medical records.

For example, although Congress expedited the drug approval process for HIV/AIDS drugs, researchers are unable to keep up with the growing complexity of the potential combinations of these drugs. To address this knowledge gap, AIDS activist Larry Kramer is collaborating with the New England Medical Center, Healtheon/WebMD, and other organizations to create the HIV: Treatment Data Project (TDP). It is an online database of self-reported information from people with HIV/AIDS about their drug treatments.

"TDP holds great promise for doctors in search of answers," says Dr. Michael Horberg, principal HIV services provider at Kaiser Permanente in Santa Clara, Ca. "Particularly in

the treatment of AIDS, doctors often have to rely on information and data from very limited and small clinical trials. Tell me about 20,000 patients instead of 20 patients and I and my colleagues will make a better decision."

Information gleaned from online medical records could also be used to evaluate the performance of health plans, doctors, and hospitals, providing patients with the information they need to select caregivers who are qualified to meet their needs.

Online records "would make our work a lot easier and accelerate improvements in quality of care," said Andrew Webber of the National Committee for Quality Assurance, a nonprofit organization that provides consumers with performance information about health plans.

The race for online medical records is underway, but a growing number of policymakers are concerned about people who do not yet have access to the Internet. Many of them are the uninsured. "Future scenarios make little if any mention of the more than 44 million Americans who do not have health insurance," says Rita Moya, president of the National Health Foundation, a California-based organization dedicated to improving access to health care. "According to Cyber Dialogue's 1998 American Internet User Survey, low income was a major barrier to accessing health and medical content online."

To address this digital divide, Vice President Al Gore has called for opening schools and libraries for public Internet access and bringing computer technology and Internet connectivity into public housing complexes, senior centers, and social-service centers.

Clearly, great momentum is gathering to propel health care information in the same direction as commerce, research, and mail: online. The current privacy debate may present a momentary glitch, just as e-commerce was initially held up while concerns over credit card security were addressed. Innovative e-business sites forged ahead, drawn by the enormous potential of the Internet market. Given the timely confluence of policy proposals, commercial investment, and convenient technology, personal health spaces and other ways of managing health information online are likely to grow — as soon as security is assured. "The opportunity to change the dynamic is there," says Jeff Blair of the National Committee on Vital and Health Statistics. "The technology is there. All we need now is the public consensus to aggressively move forward." ■

Mental Health/Resolving key issues

Fifty million Americans suffer from mental illness, says Surgeon General

Americans were startled in late 1999 when Surgeon General David Satcher presented a report claiming that more than 50 million Americans — nearly one-fifth of our population — suffer from some kind of mental illness each year. Like the famed 1964 surgeon general's report on the perils of smoking, this first-ever report on mental health focussed debate on one of the great unresolved areas of health care reform.

The Satcher report's most sobering finding was that nearly half of those afflicted with a mental disorder fail to get treatment, though adequate and affordable therapies may be readily available. The barriers are often social stigma and cost.

By laying the mental health issue squarely on the policy agenda, Satcher directly engaged one of the central issues of the current debate: *mental health parity*. Should insurers be required to treat mental illness just like any other disease, with ample coverages and reasonable rates? Satcher, backed by Health and Human Services Secretary Donna Shalala, says yes. "There's no scientific reason to differentiate between mental health and other kinds of health. Mental illnesses are physical illnesses."

Lines of disagreement on parity, however, are deeply drawn. Insurers worry that putting mental health coverage on a par with physical health will rapidly accelerate claims. Employers in turn fear a sudden leap in their insurance premiums — a very high cost for what they consider a minor need. Parity proponents argue the opposite: that giving mental health parity with other health issues will meet a great need while only marginally raising costs.

A host of other controversies surround mental health coverage, including:



Surgeon General David Satcher favors parity: "There's no scientific reason to differentiate. Mental illnesses are physical illnesses."

Confidentiality: Questions range from whether psychiatric notes are privileged to how much information should be shared with families who provide care.

Restrictive pharmaceutical formulas: Existing lists of approved and insurance-covered drugs tend to be outdated and don't include new medicines that show great promise but are also expensive.

Criminalization: Too many disturbed people are in jail rather than in treatment, where they belong.

Like so many other areas, mental health care is a field where our skills in finding solutions — through advanced drug therapies, for instance — have far outrun our capacity to deliver. Secretary Shalala says that mental illness is the second-leading cause of disability and premature death in the United States and that we face "a public health crisis."

Clearly, while continuing research is needed into what works best for patients, mental health care must be integrated into our overall attempts at reform. The parity issue, for example, should be seen as part of the larger question of universal

coverage. How hollow would the promise of coverage for everyone be if it excluded, say, heart disease? While we can't cover everything — and costs must be considered — we should acknowledge that many mental health care services are in fact cost-effective, especially compared to the price (in crime and social services) of leaving mental illness untreated.

Our challenge in mental health as in all other fields is to level the playing field, make choice and access available to everyone, and to empower Americans to remove themselves from the roster of 50 million who need help every year. We must also overcome lingering prejudices against psychological treatment by taking charge of our own mental health the same way we take charge of a cold or seek treatment for the flu. Emotional health is an important contributor to general health and longevity, and the sooner we can develop collaborative strategies among patients, providers and payers for identifying and treating such disturbances, the better off we will be as a nation.

—The Editors



Harold Varmus hopes that PubMed Central will lead to a cascade of new scientific discovery.

Resource for research

With PubMed Central, the NIH plans to make all life science research free and easily accessible. But some science journal editors are worried.

by Kerry Tremain

Just in time for the new century, the National Institutes of Health (NIH) quietly launched an innovation that promises to do for biomedical research what the Gutenberg Press did for literacy. The project is called PubMed Central, and its premise is disarmingly simple: to bring the widely scattered findings of the world's life science research together under a single electronic roof, searchable by anyone.

To be integrated with the existing PubMed biomedical database, PubMed Central is now online at <http://www.pubmedcentral.nih.gov>. The historic undertaking is the brainchild of Nobel laureate Harold Varmus. As NIH director from 1993 until 1999, Varmus's idea was to create a virtual library where anyone with a computer — doctor, farmer, biochemist, flu sufferer — could search for comprehensive and current information on the latest medical research, even if some of it hadn't yet been through the laborious peer review and publication process.

By making connections across disciplines and cultures, this huge new public database promises to be a pivotal event shaping the life sciences, where explosive growth and dramatic breakthroughs are on the near horizon. The pace and magnitude of today's research is illustrated by the Human Genome Project, the global effort to document all human genes, which last year released roughly five million new DNA base pairs every day. In scientific discovery, the traditional

image of the lone genius at the lab bench has given way to that of a networked team of researchers collaboratively pushing the scientific edge.

Varmus's concept is aimed less at consumers than at professionals. He hopes that PubMed Central will set off a cascade of new discovery in life science. And not just in the lab. Through PubMed Central, data from field and clinic will interact more easily with laboratory research, continually improving both the research and its applications.

"You might suddenly recognize, by looking at a gene sequence, that someone's study of an arcane process in fruit flies is the richest source of insight into a problem of how blood vessels develop," says Patrick O. Brown, a genomics scientist at Stanford University who consulted with Varmus on PubMed Central. "More and more scientific research involves making connections across totally unpredictable distances in the body of knowledge. Suddenly all the Balkanization of the scientific literature becomes a major obstacle. You don't have, in the small set of journals in your office, all the information you need."

Unfortunately, that small set of scientific journals is what most researchers currently have to rely on. Although some of the journals are online and searchable, the lag time between discovery and release of the data is often six months or more. Traditional journal publishing is also expensive, despite the fact that the research and peer review are mostly

done by scientists at public institutions or under public grants. Journal subscriptions can run in the hundreds of dollars, and authors may pay as much as \$1,000 to publish their articles. By contrast, through PubMed Central, even a scientist in a developing country will be able to present his or her work to the world, and in turn, have access to a vast scientific resource for the cost of a computer and an Internet connection.

Top university libraries, for those lucky enough to be near one, do stock many highly specialized journals. But any given article can take hours to track down. In today's bio-research environment, this is the equivalent of using the Pony Express to deliver mail.

Brown envisions scientists using PubMed Central to construct personalized, continuously updated journals with automatic searches and feeds for experiments related to their fields of study. Much of the information they would use will be in Part I of the site, which will consist of traditional, peer-reviewed journals that agree to participate.

Part II of the site is more controversial. For that section, a board of scientists will establish criteria for publishing reports outside of the peer-review structure. The idea is to lower the publication barriers to breaking research reports or even incomplete sets of data — thus bolstering the new collaborative methodology.

Brown believes the review procedure for Part II should be "a simple screening process that would only exclude stuff

that on the face of it is not science." He points out that scientists routinely rely on articles that are not peer-reviewed and that those who would look at these papers are self-selected people who will evaluate the data with a critical eye.

That doesn't wash with everyone, especially some of the journal editors and scientific societies. They see PubMed Central as a threat to the time-honored process of careful peer review of published articles — and a threat to their livelihood. A major shot across the bow of the PubMed Central proposal came from the prestigious *New England Journal of Medicine* last June in an editorial by one of its senior staff, Dr. Arnold S. Relman of Harvard Medical School.

Relman wrote that he is concerned that health care providers will use unreliable information from Part II and that free publication of papers on PubMed Central "would very likely reduce the submissions, paid circulation, and income of most clinical journals enough to threaten their survival."

Varmus believes the fear of clinicians' using unreliable medical data is misplaced. "The results posted...that are most likely to affect health care will have been subjected to critical review and editing by journals," he wrote in a discussion on the NIH site.

The more likely outcome, advocates argue, is that PubMed Central will radically improve physicians' practice by addressing one of the glaring faults in today's health care system: the absence of "best practices" information in the hands of those treating patients. By making information on the best clinical practices widely accessible and by expanding "bench to bedside" collaborations between researchers and clinicians, PubMed Central can help close the sometimes tragic gap between the state of research and the state of practice.

The database could also work in the other direction: bringing the unparalleled



A RACE IN GENES: The Human Genome Project, the global effort to document all human genes, releases 5 million new DNA base pairs every day.

In scientific discovery, the lone genius at the lab bench has given way to a networked team of researchers pushing the scientific edge.

daily experience of clinicians into the raw data pool available to researchers. "Every single day, detailed physiological measurements and careful observations are being made by physicians about anything that's anomalous. It's a huge raw resource for scientific discovery," says Brown, the Stanford researcher, who hopes PubMed Central will encourage doctors to report their findings. "Most of [that data] just vaporizes."

Moreover, journals' prestige and value may actually increase with PubMed Central as they spend more effort analyzing and filtering the information in the vast database, making it more useful to researchers, clinicians, and even members of the public.

Certainly, some of the kinks in

PubMed Central will have to be worked out, especially when, as Varmus hopes, it achieves greater coordination with international databases. The site is designed for continuous improvement, and many feel that PubMed Central's benefits will quickly outweigh its problems.

However the controversies and details are resolved, PubMed Central will surely revolutionize the ease and speed with which research data moves around the world. Balkanized data will be assembled and made accessible. And that, in turn, could have direct and profound implications for treatment and outcomes.

Kerry Tremain is a writer and an editor of BLUEPRINT in Berkeley, Calif.



and a
style, foc
on, n
ess
prof

The doctor in the mirror

Most medical care is self-care. Policymakers and professionals should support it.

by Michael Castleman

The person who provides most of your health care — and just about everything that has to do with disease prevention — is the person you see every time you look in the mirror. Sure, your doctor is part of your medical team, but the vast majority of medical care is self-care.

Self-care encompasses everything from lifestyle decisions to self-treatment of minor ills with over-the-counter drugs. It includes researching medical conditions you have, taking medicines when you're supposed to, and even scheduling elective surgery at major medical centers during the first half of the year (new residents always start work July 1; you get better care January through June after they've gained some experience.)

Those who are skilled at self-care live a healthy lifestyle, focus on disease prevention, manage most of their health concerns successfully at home, and consult health professionals only occasionally.

In today's health policy debate, self-care is the issue hiding in plain sight. Policy questions are almost always couched in these terms: Should government pay for X medical procedure? Should HMOs be required to offer Y? The assumption is that health care is a service handed

down from on high by omniscient, omnipotent providers to passive, uninformed, largely helpless consumers down below. The health consumer's only role is to "follow doctor's orders," a telling phrase.

The policy debate needs to shift gears and recognize that increasingly consumers are their own providers. When policymakers understand this sea change in the health system, they will stop ignoring it and instead craft policies that support and reward it.

Self-care in no way implies rejection of doctors. Many health problems require professional care, and a key element of informed self-care is to understand the limits of what non-professionals can do for themselves. Collaborative relationships between patients and doctors, based on self-care, are particularly critical in managing chronic illness.

Self-Care Rules

How primary is self-care in health care? It accounts for more than 80 percent of health care. Several researchers have camped out in the waiting rooms of family doctors to ask patients why they were there and if they had done anything for themselves before calling for an appointment. About 90 percent said they had tried self-care and had come to the

San Francisco medical journalist Michael Castleman is the author of ten consumer health books, including Blended Medicine (Rodale), a home medical guide. He is the former editor of Medical Self-Care magazine.

"About 90 percent of all care is self-care and it is certain to increase in the 21st century. It saves time and money, and can reduce the strain on overburdened health care services."

doctor only because home treatment had not provided sufficient relief.

Yet self-care is the Rodney Dangerfield of health care. It gets no respect, even though self-care saves time and money and can reduce the strain on overburdened health care services. In a report in the *Journal of the American Medical Association*, a group of family physicians divided their 875-family practice into two groups at the start of the winter cold and flu season. One group of families received printed self-care instructions for dealing with colds and flu; the other did not. By the following summer, the group encouraged to practice self-care had made 44 percent fewer office visits for upper respiratory infections. They saved themselves considerable time and money without suffering any more cold and flu complications than did the members of the control group, who had visited the doctors almost twice as frequently.

Similar studies have shown that people with chronic conditions such as arthritis and headaches also benefit from modest, short-term self-care training. Many studies show that no matter which chronic illness a person has, deep relaxation training almost always improves quality of life. This training costs much less than drug treatment and causes no side effects. Shouldn't it be encouraged?

Medicine for the New Millennium

Self-care is certain to increase in the 21st century. Managed-care companies have an enormous interest — their profit margins — in keeping people away from medical services they don't need. Of course, the managed care industry has run afoul of consumers and Congress by denying people care they do need. Such abuses should certainly be stopped. But given the rising cost of health care and the fact that we all pay dearly for overuse of medical services in higher taxes and health insurance premiums, it's clearly in the nation's interest to curtail unnecessary physician visits. The best way to do this is to encourage responsible self-care.

Many HMOs now publish or distribute self-care home medical guides to help subscribers take better care of themselves. Through

its marvelous CancerNet database, the National Cancer Institute currently provides online state-of-the-art treatment option information for every major cancer, along with information on support groups, clinical trials, and other resources (<http://cancernet.nci.nih.gov>).

Many hope that the cost of prescription drugs will soon be incorporated into Medicare. But the truth is that the cost of prescription medications is dwarfed by the price of self-care with over-the-counter (OTC) drugs with sales of some \$30 billion a year. Since the late 1970s, the Food and Drug Administration has reclassified more than 50 drugs from prescription-only to OTC.

Sales of vitamin and mineral supplements, as well as of medicinal herbs, are also booming. Articles in top medical journals have shown that they may be effective in preventing illness or improving outcomes for a variety of conditions. For example, landmark studies at Harvard published in 1993 showed a strong association between a high intake of vitamin E in diet or supplements and a substantially lower risk of coronary heart disease in both men and women. The potential for saving the lives of Americans at risk for heart disease is enormous. One percent of the money Medicare currently spends on angioplasty and bypass surgery would enable us to encourage all Americans over 50 to boost the use of vitamin E in their diets.

The Food and Drug Administration could facilitate the responsible use of supplements and herbal medicines by emulating Commission E in Germany, which scientifically judges the safety and effectiveness of such products and stipulates responsible dosages.

Home medical testing is yet another growing aspect of self-care. Not long ago, only doctors could measure blood pressure and cholesterol and administer tests to detect pregnancy, colon cancer, and HIV infection. Now home tests for these and other conditions are available. We should encourage the development of appropriate home testing.

One of the biggest items in the Medicare budget is cataract surgery. Cataracts are caused by oxidative damage to the lens of the eye,



Collaborating with your doctor

Managing chronic diseases requires partnerships / by Jessie Gruman

In the past, people often suffered and died from such acute diseases as small pox, pneumonia, or polio that came on suddenly, usually as the result of a virus or bacteria, and ended in either recovery or death. But in the last century, public health measures and biomedical advances have checked many of these diseases. Now, with the population aging, people suffer disproportionately from chronic diseases, such as diabetes or arthritis, that require regular care over a long period.

Yet our health care system has not fully adapted to this fundamental change. People are living longer and suffering from chronic diseases but are still using a system designed more for very expensive acute care, driving up overall costs significantly.

To manage chronic disease more effectively and inexpensively, we should

encourage collaborative partnerships between doctors and sufferers that involve a greater degree of self-care. There is considerable evidence that such relationships result in better health outcomes. Through study, we've learned some of the critical factors for making these collaborations work.

- The provider and patient must harmonize their view of what is going on and share decisions about how to treat problems. Individuals with chronic conditions must often change long-standing habits such as a poor diet or lack of exercise. The primary care provider is crucial for initiating and sustaining behavior change in patients, a role that some physicians are uncomfortable with.

- Managing health risk and chronic conditions requires a lifelong series of course

corrections. To avoid being discouraged, patients must have realistic expectations about a medical action or behavioral adjustment. Health care that is oriented toward giving advice, enabling collaborative planning, offering choices among effective support services, and providing follow-up care can help patients participate in their care.

Public policymakers can ensure that collaborative health care is delivered to all by supporting the development of published performance standards that measure, at both the plan and provider level, the extent to which health care is truly collaborative.

Jessie Gruman, Ph.D., is executive director of the nonprofit Center for the Advancement of Health.

The BLUEPRINT Health Index



Startling numbers bring urgency to reform

Size of the health care economy	\$1.15 trillion
The number of Americans without health insurance	44 million
The number of uninsured children	11 million
The number of lower-income (under \$20,000) workers and their families who have no health insurance	18 million
Percentage of the uninsured who have jobs (including their dependents)	85 percent
The number of uninsured children who are eligible for coverage through a government program but not enrolled	7 million
The number of working-age adults who could not pay their medical bills in 1998	39 million
The increased chances of death by being uninsured for the average person	25 percent
The increased chances of death by being uninsured for a woman diagnosed with breast cancer	50 percent within six years
Number of states that require you to have liability coverage for your car	49
Number of states that require individuals to have health insurance	0
Percentage of workers whose employers offer them no choice of health care coverage	37 percent
Ratio by which these workers grade their plans with a "C" or lower compared to those who have a choice	2 to 1
Estimated number of deaths from medical errors in U.S. hospitals	44,000 to 98,000 annually
Number caused by AIDS	16,516
Number caused by breast cancer	42,297
The number of deaths in the U.S. airline industry in 1998	0
U.S. health care spending per person in 1998	\$4,094
The number of years that national health spending has stayed the same or declined compared to the whole economy	6
The number of years that enrollment in managed care has exceeded 50 percent of the nation's population	5
Ratio of health care costs in the last two years of life for a person who dies at age 67 to one who dies at age 90	3 to 1
How much more health care costs for a chronically ill senior citizen (over 65) than for one who has maintained good health	700 percent
The current trend in disability rates	1.3 percent annual decline

Sources available at <http://www.dlcppi.org/blueprint>.

damage that can be largely prevented by not smoking, protecting the eyes from ultraviolet light by wearing UV-blocking sunglasses and a broad-brimmed hat, and eating a diet rich in antioxidants. For cataract prevention, the most potent are the anthocyanosides found in dark fruits: grapes, raisins, plums, prunes, blueberries, blackberries, raspberries, cranberries, and currants. One percent of the money currently used to pay for cataract surgery could be used to encourage Americans to eat more of these fruits.

Government could also encourage health insurers and public health departments to provide health risk appraisal screening and additional preventive care, particularly nutrition advice. More attention to public health education could help turn most people into sophisticated health consumers.

As a nation, we've already realized tremendous benefits from several public health education campaigns. Anti-smoking endeavors have sliced the number of smokers from 40 percent of the population in 1964 to less than 25 percent today (less than 20 percent in Utah and California). Government efforts to lower cholesterol, spearheaded by the National Cholesterol Education Program of NIH, have reduced average total cholesterol from 225 in 1960 to 205 today. When automobile seat belts were introduced in the 1960s, few people used them. Today, about 70 percent do. Public health education takes money and time (often a generation). But it works.

It's not enough for health care providers and insurers to stop playing God. The rest of us must get up off our knees and become assertive self-carers. Health policymakers must finally recognize the crucial importance of a well-informed public that practices appropriate self-care. While doctors and hospitals are certainly important parts of our health care system, self-care is more important. We need to reorient the health care system to support the millions of Americans who look into the mirror each morning and see their primary care practitioners. ■

What Works / Outreach in Chattanooga

Anne McGintis reaches kids through their parents / by Judy Packer-Tursman

After devoting two decades to teaching, Anne McGintis decided to go beyond the classroom in order to help underserved children in her hometown of Chattanooga, Tenn. In 1994 she began by setting up the city's first resource center for low-income families, where people could learn job skills, take classes, and get health screenings and information. Now three centers serve about 300 people weekly. She is on the lookout for any opportunity to bring together families, educators, doctors, and nurses to improve the health of people in the community.

You know my big word is collaboration. We do nothing in Chattanooga without collaborating with others. You can't do anything without the help of somebody else.

This past summer we did health risk assessments with the Hamilton County Health Department. I made a proposal to them. I said, "We have children coming for summer school, but let's take time out and look at the parents." Out of 500 kids, about 400 family members got tested.

The reason we did this is that when parents are ill, sometimes they don't push children. Often parents would tell us, "I didn't feel well. That's why I didn't come to the PTA meeting. I couldn't take them to the library. My leg hurt. My shoulder was hurting."

We wanted healthy parents to be healthy for their kids. So we did diabetes screening, mammograms, and prostate exams. We checked blood pressure; we had a nutrition specialist; we had immunizations. I think it must have been about 25 tests that they had to go through.

You know what the parents said? They said they're so glad, because we put the testing at a good time. Some of them couldn't go to doctors at the "right time," but we had some assessments early in the morning, some late in the afternoon,

and some lunch-time specials, where they could run in and do it.

We have to understand that parents are the first teachers. When that child comes home, who does that child start mimicking? That child says "mama" and "papa" first. He or she doesn't say "doctor" or "principal" or "teacher" first.

McGintis' goal is to extend her reach into those places where parents go about their daily routines.

I was talking to a beautician, and she was telling me a lot of people come in to get their hair fixed, and they feel so relaxed. She told me, "Ms. McGintis, it would be so good if we had health care material in here so that when they're sitting under the dryer they could read some stuff." So that's what we did.

She started about this time last year, and she provided a room in her shop. We sent letters out to several others, and they have pamphlets throughout their beauty salons on health issues. Some of her clients are doctors, so they talk to people about high blood pressure and healthy pregnancies.

She brings in somebody whenever there's a community issue or she hears something parents need to know, but it's up to her to do that. I've given her the material, plus I've hooked her up with the health department. See, that's col-



Anne McGintis: "We wanted healthy parents to be healthy for their kids...We have to understand that parents are the first teachers."

laboration.

McGintis works with health plans, too, in her effort to ensure that families get what they need.

A local HMO provides services at our family resource centers. One time they gave out toothbrushes because we found out as Americans we don't change toothbrushes often enough. A lot of people were keeping toothbrushes a year or a year and a half. So one day that HMO gave us thousands of toothbrushes. It's little things like that that we do.

I love the community, the partnership, and the people. But I'm only as successful as parents make me. We all do it together.

Judy Packer-Tursman is a free-lance writer and former Washington correspondent for the Pittsburgh Post-Gazette.



"Young people don't have time and attention from concerned adults"
— Father Tom Merkel

Health for Life

K-12 health education
reduces bad lifestyle choices later on

by Judy Packer-Tursman

Father Tom Merkel, who runs three schools on the Pine Ridge Indian Reservation in South Dakota, is attempting what many wealthier schools claim they can't afford. In the poorest county in the nation, he is trying to institute the kind of comprehensive health education program that experts say could benefit all K-12 schools.

In Pine Ridge, the need is stark. Health status indicators are among the worst in America. The lung cancer rate is twice the national average, and the prevalence of diagnosed diabetes is nearly three times higher. And children suffer from lack of good health education and parental involvement. "Young people don't have time and attention from two concerned adults," says Father Merkel.

In the face of this grim reality, Merkel and others decided to help children develop skills, attitudes, and habits early on to improve their chances of lifelong wellness. Both elementary schools began using "Growing Healthy," a rigorous, quarter-century-old curriculum by the New York-based National Center for Health Education. One elementary school set up a breakfast program that has reduced absenteeism and tardiness.

This fall, school officials met with public health professionals, the local hospital, businesses, and students to identify critical needs over the next five years. They want to bring back physical education for grades 9-12, set up smoke-free campuses, and create a school-based clinic.

The kind of comprehensive health education that Merkel envisions for the Pine

Ridge schools may sound logical, even obvious. But very few American schools, rich or poor, make it a priority. They should. Every day nearly 3,000 youngsters take up smoking. Among high school students, 20 percent carried a weapon in the past 30 days; 24 percent considered suicide in the past year; and 75 percent don't attend a daily physical education class.

Despite polls that show Americans believe that health education is important, government officials say it is being taught piecemeal through one-semester courses for older teens and not in a comprehensive manner from kindergarten through high school. Frequently, even those programs are led by untrained teachers.

Health officials insist that is not good enough.

"Sound, comprehensive school health education programs are essential to developing the health decisionmaking [that] young people will need throughout their lives," claims Becky J. Smith, executive director of the American Association for Health Education. Such programs teach young Americans how to stay fit, handle stress, eat well, and develop healthy relationships with families and friends — and how to become active, savvy health care consumers.

Officials at the federal government's Centers for Disease Control and Prevention (CDC) in Atlanta agree with Smith. Beyond a health curriculum, the government urges schools to create programs that include physical education, health and nutrition services, counseling, psychological and social services, a healthy school environ-

ment, health promotion for staff and family, and community involvement.

Many schools complain that they cannot afford a comprehensive approach like Growing Healthy. Others argue that families are primarily responsible for promoting wellness.

Some administrators address the cost issue by trying to convince teachers that they can teach reading, science, and other content areas through health education. But most schools simply invest in short-term programs on a topic-by-topic basis, targeting what they regard as the more worrisome behaviors among their students. "Usually health education is teacher-driven, and driven by the best salesmen, not by what the needs of the kids are," says Pete Hunt, a health education specialist at the CDC.

Unfortunately, as another CDC official concedes, there's "not a lot of empirical research that has taken school health education and done a longitudinal study on what it's done for kids." This is a circular problem. It's hard to measure the long-term effects of a comprehensive program when there aren't any adequate programs to measure.

Nonetheless, several studies have proven the effectiveness of certain programs that offer health information and life skills, citing less drug use, alcohol consumption, and cigarette smoking.

CDC's own strategy is to identify high-priority health risks for children and implement national programs to prevent these risks, while constantly evaluating and improving programs. Yet its review

has been limited to six programs so far, including four in HIV prevention and two on tobacco use.

Despite insufficient data, health curriculum costs, and other objections, some schools have taken the lead to incorporate various components of comprehensive school-based health education. For example:

- The nonprofit Education Development Center, based in Newton, Mass., offers "Teenage Health Teaching Modules" (THTM) to focus on positive behaviors, such as strengthening relationships with family and friends and handling stress. "Rather than try

to attack the health problem of the moment, THTM helps young people build skills so they have the strength to draw on in any situation," says Christine Blaber, project director. Its expanded and revised program, first offered in 1981, is being used in more than 6,000 middle schools and high schools. But they concede few schools purchase the entire 24-module curriculum; most buy one or two modules.

- In Berkeley, Calif., the Edible Schoolyard at Martin Luther King Jr. Middle School has transformed an abandoned acre-sized lot into an organic garden, which has been integrated into the core curriculum. The 900 students harvest, prepare, serve, and eat the food grown there. Chef Alice Waters, who helped launch "California cuisine" more than 25 years ago, said she began the project in 1994 to teach children "the joy of the table, the pleasures of real

work, and the real meaning of community."

- In Memphis, Tenn., the city school system has used grant money from a private foundation to extend the "Growing Healthy" program to 12,000 students at 42 elementary schools in the past three years. Dee Weedon, the system's health specialist, says the program "exemplifies the type of teaching and learning we want...You don't just sit down and read about health. You're engaged in health activities." She acknowledges Growing Healthy is very expensive, estimating the program's start-up costs at \$12,000 to \$14,000 per school for curriculum and teacher training. But she says that costs are minimal after that.

A more typical approach is that of Montgomery County, an affluent Maryland suburb of Washington, D.C. While the public school system has developed its own instructional materials and health objec-

tives, they only require a one-semester course for high school graduation. The course touches on mental health, tobacco, alcohol and other drugs, nutrition and fitness, and injury prevention.

"When you purchase a commercially prepared curriculum, it's very costly for a school district the size of Montgomery County," says Russell Henke, coordinator of health education for the county's 130,000 students. "And health education doesn't have a lot of money devoted to it."

This may be true. But at the Pine Ridge schools, which nearly closed two years ago for lack of funds, Father Merkel is demonstrating that it may also be a matter of priorities.

Judy Packer-Tursman is a free-lance writer and former Washington correspondent for the Pittsburgh Post-Gazette.



Health education teaches children how to stay fit, handle stress, and eat well.

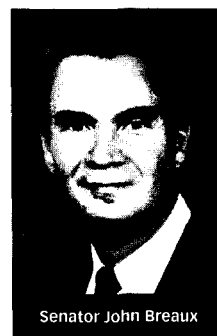
"Very few American schools make health education a priority. Every day, nearly 3,000 youngsters take up smoking. Last year, 75 percent did not attend a daily phys ed class."



Troubled Medicare can be ushered into the 21st century only by getting politicians out of the medical business. We can cut costs by offering seniors greater choice *and* prescription drug coverage.

Save Medicare from itself

by Senator John Breaux



Two years ago, as a member of the Senate Finance Committee, I was treated to the spectacle of full-color lobbying by representatives of the health care industry. First came the gastroenterologists. Setting up their screen and projector in my office at the U.S. Senate, they showed me vivid pictures of unhealthy colons to convince me that Medicare's cancer screening benefits should include flexible sigmoidoscopies and colonoscopies, which they perform, instead of barium enemas, which are done by radiologists.

The radiologists came later with their own charts and dramatic color pictures. They argued that you can't just rely on colonoscopy to detect colon cancer, but you need barium enemas, too, and these should, of course, be covered under Medicare.

There's something wrong here. I'm a U.S. Senator, not a doctor. As a politician, I have no business making detailed medical decisions, rendering judgments on treatment, or deciding what price to pay for every single procedure that is done in a doctor's office. And yet that is just what we do in Congress.

That will change if a new Medicare reform bill — the Medicare Preservation and Improvement Act — passes the Congress in 2000. Sponsored by me and the only actual physician in the U.S. Senate, Republican Bill Frist of Tennessee, this legislation will usher politicians out of the medical business and back into policymaking. More important, it will bring Medicare into the 21st century — and not a day too soon.

GOLDEN MOMENTS: Without Medicare reform, future generations of Americans might not be covered in their senior years.

Democrat John Breaux is the senior U.S. Senator from Louisiana and chairman of the National Bipartisan Commission on the Future of Medicare. He was assisted in the writing of this article by Jeff Lemieux.

Most seniors don't want Medicare changed. But it will be broke in 15 years if we don't reform.

Medicare is a troubled program, an outdated entitlement that is governed by arbitrary political and budgetary goals and managed by command-and-control regulation. When it was started in the 1960s, Medicare was the best system we could design, the state of the art. But everything has changed dramatically since then. We've changed the way we deliver health

care, the way we treat people, and especially the medicines we use. But we haven't changed Medicare very much since 1965. Mostly, we've just put more money into it. That is like putting new gas in an old car. It's still going to run like an old car. Medicare today is running like a '65 Chevy.

What's wrong with the program? Hospital administrators, doctors, and private health plan managers complain that Medicare's payments are insufficient. Beneficiaries complain that its coverage does not protect them from huge out-of-pocket costs, especially for prescription drugs. Taxpayers know that Medicare's explosive spending, left unchecked, will crowd out other priorities, like defense funding and education.

Because the benefits in Medicare's traditional government-run program are now so out-of-date, most beneficiaries are forced to obtain supplemental coverage for its gaps, often at great expense. Medicare beneficiaries now pay 47 percent of their health care out of their own wallets. Medicare doesn't cover prescription drugs, eyeglasses, or long-term care. It doesn't cover nearly as many things as my Senate staff and I receive as federal employees.

This is wrong — especially the lack of coverage for prescription drugs. Today, drugs are as important, if not more important, than a hospital bed was in 1965. When Medicare was designed more than three decades ago, the question was: how many days can we keep you in a hospital? Today the whole thrust of medicine has changed. The question is: how do we keep you out of the hospital? And correct use of prescription drugs is one of the key ways to keep people out of hospitals. Yet Medicare doesn't cover them.

Because of the huge gaps in Medicare coverage, nearly one in every six seniors has enrolled in a health maintenance organization (HMO) instead of the government-run plan. HMOs that have been checked and approved by the Medicare program usually have comprehensive benefits so that no gap coverage is needed; most cover preventive screenings and have at least some coverage for prescription drugs. But the way Medicare pays HMOs, which Congress attempted to improve in



1997, remains a disaster, and some HMOs have stopped offering Medicare coverage altogether.

The cause of Medicare's problems is simple, but very hard to solve. Congress is just not fit to micromanage a complex health program like Medicare. The federal bureaucracy is also responsible for Medicare's problems. The Department of Health and Human Services (HHS), which runs Medicare on a day-to-day basis, is content to translate the already complicated laws passed by Congress into a stupefying tangle of rules and regulations. (Medicare has three times more pages of regulations than the Internal Revenue Service has — 130,000 pages.) The program does not take a forward-looking management role. There is little accountability and no trust — Congress blames HHS and HHS blames Congress when things inevitably go wrong. That is why Congress tries to fix Medicare year after year but its problems never seem to go away.

Some of the recent laws on Medicare have contained important reforms, like reducing overpayments and limiting fraud, and some were simply financial gimmicks. But all of the changes amounted to tinkering around the edges of the program's real problems. None of the recent laws fundamentally remade Medicare into a sustainable, modern program for the 21st century. None started a process that would allow seniors to take control of their health benefits. None started the cultural change that must take place so that doctors and patients make decisions about patient care, not U.S. senators nor federal regulators.

The goal of real Medicare reform is to create a more flexible and modern program. The Breaux-Frist bill would give seniors the same types of choices currently available to government workers under the Federal Employees Health Benefits (FEHB) program. It would help tame Medicare's high costs, improve the quality of care that seniors receive, and help seniors who need modern health benefits. For the first time, beneficiaries would be offered reasonably

A worthy trust fund

by Jeff Lemieux



Solving the Medicare numbers game

When politicians pronounce the coming insolvency of Medicare, they are talking about the Medicare Part A trust fund. The Part A fund, which finances hospital and related care mostly from payroll taxes, is expected to be bankrupt soon after the baby boomer generation begins to retire. Medicare's Part B fund, on the other hand, which finances physician and outpatient care, is mostly funded from general revenues (75 percent) and beneficiary premiums (25 percent). Since the general revenues are unlimited, the Part B fund can never go broke. Total Medicare spending — from both funds combined — was \$212 billion in fiscal year 1999.

To extend the life of the Part A fund, politicians recently agreed to shift spending for home health benefits from Part A to Part B. More recently, President Clinton has proposed large new general revenue transfers to the Part A fund. Both types of transfers are essentially gimmicks, designed to obscure Medicare's financial problems rather than solve them.

A wiser approach would be to combine into a single trust fund the three sources of Medicare funding: payroll taxes, premiums, and general revenues. Payroll taxes and premiums are inherently limited because elected officials must take painful actions to raise funds from those sources, directly alienating constituents. Without an explicit limit, however, general revenues could expand indefinitely — putting the lie to the principles of a trust fund.

Therefore, we should place a limit on general revenues to provoke a debate over how much Medicare should rely on each of the three funding sources. That would permit consideration of the President's effort to transfer more general revenues into the program without creating a black hole of unlimited funding. As a consequence, we could maintain Medicare's fiscal integrity while exploring the proper balance of funding.

To read the Breaux/Frist Medicare bill, see <http://www.dlcppi.org/Health> or <http://www.senate.gov/~breaux>.

For more information about the Bipartisan Medicare Commission, see <http://medicare.commission.gov>.

For a description of the President's Medicare proposal, see <http://www.pub.whitehouse.gov> (July 2, 1999).

"The federal employees' health insurance program is a stable, non-bureaucratic model that Medicare could follow. Employees choose from plans ranging from fee-for-service to HMOs to everything in between."

priced drug coverage from a wide variety of all-in-one health insurance packages. They would also get more flexible benefits (including the latest tests and treatments), a reduced need for supplemental coverage, and the potential for lower premiums.

For hospitals, doctors, and other health care providers, Medicare reform would bring a less heavy-handed approach to cost control than has been used in the past. For health plans (either HMOs or more traditional plans), the bill offers greater stability and a more businesslike atmosphere, with fairer but tougher competition. And for taxpayers, the bill's reforms would help control the budget and gradually reduce the need for federal micro-management.

Getting Costs Under Control

Reforming Medicare would put beneficiaries, not politicians and bureaucrats, in charge of Medicare's costs. Empowering beneficiaries by fixing the way Medicare sets premiums for beneficiaries and payments to health plans like HMOs is the first step toward reducing costs for both seniors and taxpayers.

Whether or not a beneficiary joins a Medicare HMO or the traditional government-run plan, every senior citizen now pays a premium of at least \$45 a month. In addition, Medicare payments to HMOs are set by the government, not markets, based on historical expenditures in each county of the country. Those historical expenditures, however, were often skewed by fraud, inexplicably varied practice patterns, and special payments not related to patient care. As a result, payments are often inappropriate by locality — sometimes too high, sometimes too low. That discourages private health plans from offering alternative coverage across large areas of the country.

By contrast, the federal employees' health insurance program is a stable, non-bureaucratic model that Medicare could follow. Federal employees choose from health plans ranging from traditional fee-for-service plans to HMOs to everything in between. They receive clear comparative information about the available plans. If they choose expensive plans, they

pay more. Inexpensive plans have lower costs both for the enrollee and the government. The largest plans in FEHB, like Blue Cross and Blue Shield, have been around for decades.

Under the Breaux-Frist reforms, health plans would set their premiums, and seniors would select the plan that suited them best. Like federal employees, they would pay the extra cost for plans priced above the average. If they chose a sufficiently low-priced plan, however, they could reduce their premium to zero. In my opinion, seniors will keep costs in line far better than price controls originating in Washington. In any event, a fair and competitive system, relying on market forces, would assure us that seniors and taxpayers are getting their money's worth from the Medicare program.

Quality of Care for Seniors

Medicare's traditional program by its nature allows unlimited services, but it has no quality improvement features. Despite the huge repository of claims data, which could be researched to create reports on quality and efficiency of care, Medicare is unable to give seniors information on which doctors and hospitals do the best job and which types of care give the best results. Even with unlimited coverage, beneficiaries in the government-run program often get inappropriate care. Systematic studies of Medicare patients with diabetes or a heart attack demonstrate that many do not get the recommended treatments and tests. And many are among the tens of thousands of Americans who die every year because of medical errors.

The new quality requirements for Medicare HMOs that Congress passed are better than nothing, but not by much. They emphasize bureaucratic processes, not quality outcomes. Plans are required to put quality control systems in place, but are not obliged to demonstrate that their systems result in excellent care and successful cures. Despite the extra paperwork, Medicare beneficiaries do not have clear information about which health plans (and their affiliated doctors and hospitals) provide the best advice and care.

Admittedly, there is only so much that health insurance plans can do to ensure that their enrollees receive excellent care. But a competent Medicare board — the new entity that would supervise all health benefits and premiums under our reform proposal — could play an important role by requiring all competing health plans to report on the successes and failures of the care their enrollees receive. Comparative information on quality can help seniors choose doctors, hospitals, and health plans. That, in turn, will reward excellent health providers with additional patients, and will prompt health providers linked to poor outcomes to make the needed improvements.

Modernizing Medicare's Benefits

Under Medicare reform, all plans — private and public, HMO and traditional — would be required to offer a high option that had comprehensive benefits and prescription drug coverage. We propose that the federal government fully subsidize high option coverage for all poor and near-poor seniors and partially subsidize high option coverage for those seniors with higher incomes. Those subsidies would be expensive, but in the context of real Medicare reform, they would be worth the price.

Just as important as new drug benefits, HHS must transform itself from a passive regulator to an active manager, focused on operating the government-run plan in a businesslike manner and working to provide the best benefits and best value for seniors. With technical assistance from the new Medicare board, the government-run plan could more quickly adapt its coverage and payments to changes in health care that take place every day without, literally, an act of Congress. Achieving that sort of flexibility will require a large investment in trust-building between the bureaucracy and Congress, but that too will be worth the effort. With a fair and open system for competition in place, Congress should gradually relax its micromanagement as HHS takes more responsibility for the traditional plan. ■

A will to reform?

by Jeff Lemieux



Politicians know the problem, but change is hard

To their credit, Congress and the White House recognize that Medicare's current political and administrative setup is unwieldy and inefficient. They know that seniors, health care providers, and taxpayers deserve better. That's why the political leadership formed the National Bipartisan Commission on the Future of Medicare.

After a year of deliberation, the Medicare Commission's majority proposal was released in March 1999. President Clinton's counterproposal, which was submitted three months later, was similar in most respects. Both would put the traditional government-run plan into direct competition with private health plans in a system modeled on the Federal Employees Health Benefits (FEHB) program. Both proposals would allow seniors to pocket most of the savings if they chose inexpensive plans. And both would give the government-run plan more flexibility to innovate and compete.

Neither plan is a radical privatization that could disrupt seniors' health care. Instead, beneficiaries and taxpayers would share the costs and savings as overall health costs ebbed and flowed. Both proposals would add a prescription drug benefit and other benefits as voluntary options. Both would require that beneficiaries, not taxpayers, pay most of the cost of the new benefits, but both give extra financial assistance to low-income seniors.

The new bipartisan Breaux-Frist Medicare bill bridges the remaining gaps between the Medicare Commission's outline and the President's plan. It drops the Medicare Commission's proposal to raise the age of eligibility from 65 to 67 and it adds a universal, although still means-tested, subsidy for drug benefits. (President Clinton had insisted on both changes after the Medicare Commission released its plan.)

So a consensus on what to do is emerging, but it is unclear whether politicians can muster the will to go forward. They are constrained by potential costs and political fear. Some liberal politicians still denounce any competitive reforms as an attack on seniors, despite the appeal of new drug benefits. Some conservatives decry what they see as the high price of modernizing Medicare's benefits. (The Medicare Commission's plan would have saved a good deal of money. The President's plan would increase Medicare spending. The new Breaux-Frist bill attempts to balance new costs with new savings in the short run, and it promises more significant savings in the longer run.)

Progressives on both sides of the aisle should resist those who would rather do nothing, however. They should not squander a historic opportunity to help seniors and build trust with taxpayers at the same time.

What's your plan?

Most people don't have long-term care insurance, a fact that could bankrupt both government and families. Here's a better plan.

by Eric B. Schnurer

If you've ever watched those TV commercials about the joys of growing old — like the one where seniors barrel down the road in a convertible while guzzling a nutritional supplement — you may have wondered whether there are any downsides to aging.

If so, you could — as I did — hit the Internet site of Americans for Long-Term Care Security (www.ltcweb.org). There you can click on your age, gender, and home state and learn the costs of the long-term care (LTC) you can expect over the remainder of your life to help you perform the daily tasks of living as you age, plus the odds that you'll require a nursing home stay. The figures for me (a 41-year-old male Pennsylvanian) came to nearly \$170,000 with a 30 percent chance of institutionalization.

Granted, this site is backed by the insurance industry, with an interest in scaring you silly. But the facts are that two in five Americans will require nursing home care at some point, more than half of them for at least a year — and a year in a nursing home now averages \$50,000. And that means that if you're thinking about the future tab for yourself, your spouse, and two parents or in-laws, you're looking at a bill far in excess of

the average house purchase in this country.

Of course, if you are thinking about this at all, you're in the distinct minority. Estimates are that 9 percent of the potential customers have actually bought LTC insurance. Surveys show that four out of ten Americans believe that Medicare will cover such expenses.

Unfortunately, it won't. Instead, Medicaid, the government health care program intended for the poor, has been stuck with the biggest tab for LTC, even though most beneficiaries aren't poor. Medicaid already spends nearly 40 percent of its budget to finance long-term care for the elderly, paying for two-thirds of all nursing home residents in the country. As these numbers grow, Medicaid could supplant Social Security and Medicare as the largest item in the federal budget. And grow they will: Over the next 40 years, the number of Americans in nursing homes will more than double. If Social Security and Medicare are taking on water, LTC costs threaten to become a governmental *Titanic*.

How did Medicaid, originally designed to provide medical care for poor families with children, become a back-door entitlement to long-term health care for middle class

Eric B. Schnurer is president of Public Works, a public policy analysis and consulting firm in West Chester, Pa.



Over the next 40 years the number of Americans in nursing homes will double, with costs averaging \$50,000 a year. Already, Medicaid — a program designed for poor families with children — pays for two-thirds of all nursing home residents. It has become a backdoor middle-class entitlement.

"Real choice entails real responsibilities. In long-term care, this means ending the de facto entitlement program for people who don't need government aid."

families? Because Congress keeps raising Medicaid's threshold of "poorness," enabling many middle class Americans to sneak under the eligibility wire by transferring assets to relatives before they die. Nowadays, you have to be really rich and have a really bad lawyer not to be able to induce the public to pay for the LTC costs you didn't think to plan for yourself.

It's hard to imagine a less efficient or equitable way to deal with Americans' growing demand for long-term health care. The alternative to Medicaid's backdoor entitlement is private insurance — but who wants to buy a costly long-term health insurance policy if they think Medicaid will pick up their costs for free?

There's a three-part answer to this dilemma. First, we must close the loopholes in Medicaid, making it difficult if not impossible for relatively well-to-do families to game a system meant for the poor and instead encourage all Americans, rich and poor alike, to care for themselves to the extent they can. Second, government can rectify market failures by investing in "public goods," promoting greater availability of information, and stimulating demand for LTC insurance. Third, we must empower people to care for themselves by ensuring a more competitive market for long-term health care, making it easier for people to buy insurance and to pool their purchasing power to get better deals, and provide help to those who can't in a way that enhances value for all. This would be part of an approach to government's role that I call competition.gov.

Competition.gov says government will work better, and its programs will be better accepted, when people can voluntarily choose how much government they "buy." But under competition.gov, not only will market competition encourage better government, government will also encourage better market competition: The more government polices the market by competing with it, the less it needs to do so by regulating it. Can government actually compete with the private sector? In many instances, it already does: Compare the price of express mail from the Post Office with that of private overnight services — or try to find an investment manager who will handle your money for the 2 percent administrative

overhead of the Social Security Administration.

Health insurance, like long-term care, offers another opportunity. Government can also make businesses compete harder by aggregating consumer power: The buying clout of the Federal Employees Health Benefits Plan (FEHBP) already drives better insurance deals for thousands of government employees — and could for others, as well.

Here are the steps we should take to create a comprehensive, public-private system of long-term health insurance for all Americans:

- Ask not what your country can do for you until you've first done what you can for yourself. All Americans must either buy long-term care insurance, or be prepared to spend down their assets before the public steps in to pay any of their bills.

- Real choice entails real responsibilities. In long-term care, this means ending the de facto entitlement program for people who don't need government aid, didn't provide for themselves but simply have good lawyers. Telling people the government will care for them anyway, even if they shirk their self-responsibility and game the system, cheats those who take care of themselves. Thus, people who do not buy insurance will have to pay their LTC bills out of their own pockets until they have completely spent down their assets. Gaming the system would be discouraged through recovery of any public LTC expenditures — plus a penalty — from the beneficiary's estate and aggressive efforts to combat asset transfers to other family members.

- The government should work to lower long-term care costs, generally, by funding medical research and by restructuring its own health care programs to encourage long-term investments in prevention.

- Meanwhile, government can help empower everyone to take responsibility for insuring themselves through public education on long-term health care costs and risks, and better access to information, including consumer report cards on the quality of various LTC options, public and private.

- To facilitate that, and ensure that low-income workers have coverage as a "default," workers should be allowed to pay LTC insur-

ance premiums through the payroll deduction system.

- And government ought to offer a competitively priced LTC policy of its own to spur competition and thus lower prices. The costs of insurance are currently too high in part because, in a sort of Catch-22, not enough people buy it to form an adequate pool, driving up the cost per head. Policies providing unlimited protection against high-end exposure are particularly hard to come by. The government could break this cycle by offering actuarially sound insurance policies priced to an expanded, mature market. By widening choices and spurring competition, government can help “bootstrap” the market to a higher level of output and efficiency.

- This government insurance would also ensure that the market stays competitive, massing buying power and market clout to drive better bargains for consumers — as with FEHBP — and economies-of-scale to offer consumers competitive options that would require private insurers to keep pace or lose business. Anyone could opt for the government insurance deal — but, unlike under a mandatory government program like Social Security or Medicare, they’d be free not to.

- Tax policy can provide incentive and assistance to middle class Americans to meet their own needs, while encouraging insurers to generate proper products. Washington should use tax credits to help people buy insurance rather than to help them defray out-of-pocket LTC costs, as the Clinton Administration has proposed. In addition, such credits should only be available for purchase of policies meeting minimum coverage standards, especially provision of unlimited, uncapped coverage to reduce those left exposed to the risk of impoverishment and the consequent need for Medicaid’s help. In this way, government would use the market’s “invisible hand” instead of the heavy hand of regulation, to spur socially responsible private behavior by both individuals and industry.

- Finally, the government would provide subsidies to those who need them. Lower-income families would be able to buy the government insurance for an income-adjust-

ed reduced rate, which would be facilitated by use of the existing payroll system — but they could receive a card or voucher allowing them to use the equivalent of their government “subsidy” to purchase private insurance coverage instead.

Medicaid, in short, would be refocused primarily on providing the poor with insurance coverage beforehand rather than inefficient care later, in a way that makes self-responsibility realistically affordable. This change would make Medicaid consistent with the middle class tax incentives proposed to shift emphasis from subsidizing care costs to subsidizing insurance purchase. Isn’t this kind of subsidy program still just another form of welfare? No, because it’s intended to foster a private market in long-term health insurance — and in ways that create benefits for all, not just the needy — rather than simply transferring wealth from one set of pockets to another. Bringing together more purchasing power helps everyone; this is compounded in insurance, where the “law of large numbers” basically makes costs per person lower the more people are in the pool. Even if we have to partially subsidize some, everybody benefits.

In competition.gov, everyone will choose their own level of government reliance — always with the option of private alternatives if they think they can do better. Everyone will assume primary responsibility for themselves — with society helping to the extent they actually need it, and even then with market empowerment not entitlements. And the government will aggregate public purchasing power and use its economies of scale to “keep the marketplace honest,” while also investing in the public goods and public functions that only government can provide, to help reduce costs and thereby make care more affordable for all. ■



WHEN TO PLAN? Young Americans, like this couple at a car dealership, need to start shopping for long-term care insurance while they’re healthy. Yet only 9 percent of the potential market has actually bought coverage. Most people erroneously believe their long-term care will be covered by Medicare or private insurance.

Health care is back

by Mark J. Penn

As we enter the 21st century, health care has risen to the top of the American political agenda. In the primary races of both political parties, health care is a key topic and one of the most obvious ways to distinguish among the presidential candidates. Two of the biggest issues are the 44 million Americans without health insurance and the rising cost of our health care system.

In a poll of 500 registered voters conducted Dec. 19-20, 1999, for the DLC (margin of error +/- 4.4 percent), we examined people's satisfaction with their health care and with the health care system, and explored their support for some new solutions to the problems confronting the system. We found that people are eager for proposals that would give them more choice over their health plan, empower them with information on the quality of care and success rates of doctors and health plans, give people new opportunities to purchase health insurance, and make people responsible for purchasing insurance if it were made affordable.

Some of our key findings:

- Americans are generally satisfied with their own doctors and health coverage.
- Of those who are not satisfied, more than half say they do not switch because it is the only or the best coverage their employers offer.
- But people strongly support reforms of the system to give *them* — instead of their employers or the government — more choice in selecting health coverage and to expand coverage as a way of keeping down per-person health care costs.
- Although a majority say they have enough information to choose a good health plan and doctor, three-quarters say that if the government required health plans to publish information about the quality of care they provide, people would use that information.
- Internet users, Generation Xers, and Wired Workers — people who frequently work on a computer and like working as part of a team — are the strongest supporters of expanding access to health care information.
- Universal coverage remains a popular idea. People support a combination of approaches — rather than a single program — to expand coverage to more Americans.
- Americans are willing to make their medical records available to doctors and researchers, with their privacy protected, if doing so would improve the quality of their care.
- The issue of long-term care needs more public discussion and education and is a prime area for reform.

Mark J. Penn is the president of Penn, Schoen and Berland Associates, Inc., and the pollster to President Clinton. Research and polling assistance provided by Jeff Epstein.

Full results of this poll can be found at <http://www.dlc.org/blueprint/spring/00/poll.htm>.

The Poll

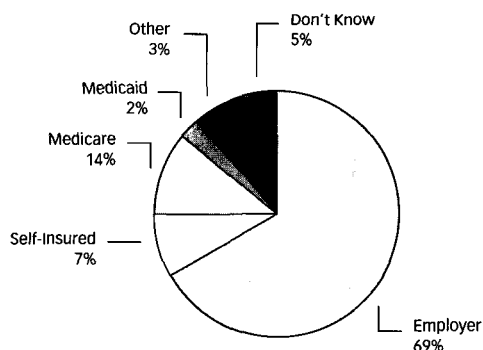
1. Current Profile of Health Care Coverage

To gauge people's attitudes toward health care and the health care system, we began by assessing the type of coverage people have and where they get it. The story here is that a large majority of people are given only certain limited choices in their health plan and their health care.

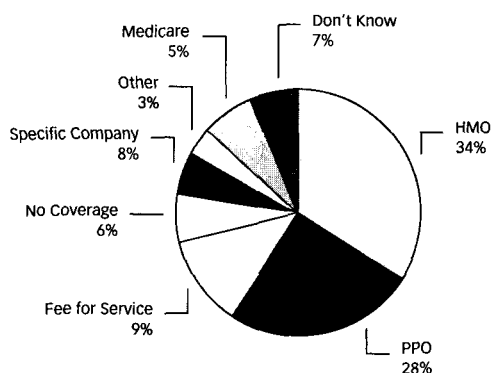
In our sample of 500 registered voters, 94 percent said they have some sort of health care coverage. Of those, 69 percent said that coverage comes from their employer — only 7 percent are self-insured. Thus, for the great majority, their choice of a health plan is limited to the options offered by their employers.

Within the coverage plans people have, there are still further constraints on choice. A total of 34 percent are covered by health maintenance organizations (HMOs), and 28 percent are covered by preferred provider organizations, or PPOs (for a total of 62 percent) — both of which limit full coverage to doctors within the plan. Only 9 percent of people are in fee-for-service plans.

Does your coverage come from your employer, are you self-insured, does it come from Medicare or Medicaid?



What kind of health care coverage do you currently have?



It is worth noting that health care coverage continues to be distributed unevenly by race and income. Although only 6 percent of the general public say they have no coverage, more than twice that number (13 percent) of African Americans and 9 percent of people earning less than \$35,000 say they have no coverage.

2. Current Levels of Satisfaction

Satisfaction with Coverage

Despite the publicity the health care issue is getting around the country and the perception that HMOs are unpopular, most people say they are very satisfied with their coverage (59 percent), including 56 percent of those in HMOs. Overall, 87 percent say they are satisfied, and only 10 percent say they are unsatisfied.

But even on this initial measure, it is clear that health care remains a somewhat more important issue for suburban voters and women with children; both groups are slightly less satisfied with their health coverage. Of those in the suburbs, 55 percent are very satisfied with their health coverage, compared with 62 percent in the city and 60 percent in rural areas. And 53 percent of women with kids are very satisfied, compared with 59 percent overall.

Q: How satisfied are you with your current health insurance coverage?

	All	City	Suburb	Rural	Women w/ kids	HMO
Very satisfied	59	62	55	60	53	56
Satisfied / Unsatisfied	87/10	89/8	86/12	85/11	85/13	89/9

Of those who are not very satisfied with their coverage, the most common reason is cost. A total of 20 percent say high copayments, deductibles, or premiums are the reason they are not more satisfied. A total of 18 percent say they are not very satisfied because their plan does not cover such things as dental, vision, or prescription drug costs.

Here, too, we found a difference among urban, suburban, and rural Americans. While suburban and rural voters cite cost most often as the reason for their dissatisfaction (16 percent and 30 percent, respectively), city dwellers point to limits in their coverage as the top reason for their dissatisfaction (22 percent). Probably due to the frequent doctor visits and associated copayments that come with having a child, 30 percent of women with children are most concerned about cost and only 19 percent of them about limited coverage.

Q: IF DISSATISFIED OR SOMEWHAT SATISFIED:

	All	City	Suburb	Rural	Women w/ kids
High copay / deductible / premiums	20	18	16	30	30
Not enough coverage	18	22	11	23	19
Have not used health plan yet	8	5	13	6	0
No particular reason	5	7	3	5	7
Unable to choose own doctor	4	8	5	0	4
Poor / slow service	3	3	2	5	3
Lack of choices	3	4	3	4	2
Don't like doctor	3	3	6	0	7
Billing issues	3	2	5	0	1

Although people give a range of reasons for their dissatisfaction with their health plans, most (52 percent) who are not very satisfied with their coverage say they do not switch plans because the choices they have from their employers do not provide a better option; another 9 percent say a pre-existing medical condition prevents them from switching. Only 11 percent affirmatively choose to remain in their plan in such circumstances, because although they are not fully satisfied with their plan, it is no worse than others.

Q: IF DISSATISFIED OR SOMEWHAT SATISFIED:

Given that you are not entirely satisfied with your health plan, which of the following best describes why you do not switch plans?

	All
Only plan my employer offers	29
Best plan my employer offers	23
All plans have their problems, and the plan I have is no worse than others	11
I can't because of a pre-existing condition	9
I do not have enough time to figure out another plan that's better	4
I do not have enough information to know which other plan might be better	3
There's no one whom I can consult with to find out the best plan for me	3
I would have to change doctors	2

Satisfaction with Doctor

A major factor in people's satisfaction with their health plans is that they are overwhelmingly satisfied with their doctors, who in many ways serve as the embodiment of their health coverage. More than 70 percent say they are very satisfied with their doctor, and a total of 89 percent are very or somewhat satisfied, compared with just 3 percent who are dissatisfied.

Of the 20 percent who are dissatisfied or only somewhat satisfied with their doctor, the most common reason is that the doctor is too busy and getting appointments is too difficult. But as to why people do not switch, 20 percent say it is because they do not have enough information to know which other doctor might be better; 16 percent say it is because they do not have enough time to find another doctor who might be better; and 6 percent say they do not have anyone to consult with to find a better doctor, all of which suggests that there is a shortage of readily available information for people to consult in making choices about doctors. Just 19 percent say they do not switch doctors because their doctor is as good as any other.

Q: IF DISSATISFIED OR SOMEWHAT SATISFIED:

Given that you are not entirely satisfied with your doctor, which of the following best describes why you do not switch doctors?

	All
I do not have enough information to know which other doctor might be better	20
No doctor is perfect, and mine is as good as any	19
I do not have enough time to find another doctor whos better	16
The health plan I have does not offer another doctor I like better	11
Theres no one whom I can consult with to find a better doctor	6

Indeed, when Americans do switch doctors, they most often rely on word-of-mouth recommendations from family and friends (34 percent) or from other doctors (22 percent) to make their decision, rather than on information they might find through their own research, such as the doctors education and training (3 percent) or a review of the doctor in the media (1 percent).

Q: When you have switched doctors in the past, which of the following information was most important in finding a new doctor?

	All
Recommendations from friends or family	34
Getting a recommendation from another doctor	22
Location of the doctor	15
Doctor's hospital affiliation	6
Where the doctor received his or her education and training	3
Reviews of doctors in magazines or newspapers	1
Seeing the doctor's name in an advertisement	1

Satisfaction with Available Health Information

Despite the concern about the availability of health care information among those not entirely satisfied with their doctor, most people are satisfied with the amount of information available. Two-thirds (67 percent) say they know enough about the quality and service of their health care and insurance, about the same number who are very satisfied with their doctor, and a majority (51 percent) say there is enough information available for people to find the best doctor and health plan.

However, certain groups are less likely to feel as confident that they have enough information about their health plans. A total of 37 percent of women with children at home and 42 percent of those earning under \$35,000 per year say they don't know enough, compared with 30 percent overall. And Democrats and Independents also are more likely to feel that they do not have enough information.

Q: Do you think you know enough about the quality and service of your health care and health insurance or not?

	All	Women w/ kids	<\$35K	>\$35K	Dem.	Rep.	Ind.
Yes	67	61	55	71	65	75	62
No	30	37	42	25	31	23	34

Q: Do you think there is enough information available for people to find the best doctor and health plan for themselves?

	All	M	F	<\$35K	>\$35K	Dem.	Rep.	Ind.
Yes	51	54	48	47	55	46	55	52
No	42	39	44	48	39	47	32	44

3. Views on Possible Reforms

Expanding Coverage to More Americans

People continue to view the system's failure to cover all Americans as the top health care problem for the government to address (29 percent), somewhat ahead of containing costs (22 percent) and improving the quality of care and reducing medical errors (22 percent). Even among Republicans, 23 percent cite universal coverage first, showing the strength of this issue across party lines. Urban voters are especially concerned about universal care, compared to suburban and rural voters.

Q: When it comes to our current health care system, what do you think is the most important problem for the government to address?

	All	City	Suburb	Rural	Dem.	Rep.	Ind.
Insuring everyone	29	33	23	30	35	23	28
Containing health care costs	22	17	22	28	17	23	26
Improving the quality of care and reducing medical errors	22	22	22	22	21	21	25
Securing Medicare	11	12	10	10	11	17	6
Giving people in HMOs certain rights	7	8	8	3	9	7	5

Overall, a majority of 52 percent rank universal coverage as the first or second most important health care problem.

Q: When it comes to our current health care system, what do you think is the most important problem for the government to address? [1st + 2nd Choice]

	All	City	Suburb	Rural	Dem.	Rep.	Ind.
Insuring everyone	52	53	42	60	62	44	49
Improving the quality of care and reducing medical errors	44	41	49	42	45	41	47
Containing health care costs	42	39	39	52	38	45	45
Securing Medicare	25	28	21	25	24	29	23
Giving people in HMOs certain rights	18	22	19	9	18	20	16

But for many Americans, expanding coverage to more people does not necessarily mean coverage for all medical expenses. When asked what is the most important reason to have health care coverage, a plurality of 42 percent say to cover the costs associated with major illness or accidents. Just over a quarter (27 percent) say to cover routine and preventive care.

Q: What do you think is the most important reason to have health care coverage?

	All
To cover the costs associated with major, life-threatening illness or accidents	42
To cover routine and preventive care	27
To cover care for chronic illness	13
To cover prescription drug benefits	9

Though people like the goal of expanding coverage, they are less sure of the means. Indeed, most voters favor a combination of approaches over any single program. Thus, only 19 percent support expanding existing programs such as Medicaid to cover more people, and just 15 percent favor giving people a tax credit to pay for more coverage. But, 44 percent favor an approach that combines the two options. Only 17 percent, including 28 percent of Republicans but just 7 percent of Democrats, say the government should not get involved in this issue.

Q: If the government decided to help people get health care coverage, which would be the best way to help?

	All	Dem.	Rep.	Ind.	GenX.
Expand existing programs like Medicaid to cover more people	19	31	10	16	13
Give people a tax credit they could use to pay for coverage	15	13	18	13	21
A combination of these two approaches	44	44	38	48	52
The government should not get involved in this	17	7	28	18	11

To get universal coverage, many people would accept a system that, as is the case with auto insurance in many states, requires everyone to have insurance, so that the increased competition helps keep costs and premiums down. Six in 10 (61 percent) would support such a system, with particularly strong support among Democrats (70 percent).

Q: If the government helped make health insurance affordable for everyone in need, would you favor or oppose making health insurance mandatory, just like auto insurance is for drivers, to lower insurance premiums and increase choice for everyone?

	All	Dem.	Rep.	Ind.
Favor	61	70	57	56
Oppose	30	22	34	34

Providing Individuals More Choice

Despite their general satisfaction with their health coverage and doctor, as discussed above, Americans would prefer a health care system that gave them, rather than their employer or the government, the primary role in selecting a health care plan. Nearly two-thirds (64 percent), including a majority of Republicans, Democrats, and Independents, say they are better able to select their health plans than their employer, and only about a quarter (27 percent) say employers are better able to find the best plans.

Q: Which is closer to your view?

	All	Dem	Rep	Ind	Wired Workers	GenX
Individuals are best able to choose the health care coverage they want so they should have that option and not have to take just what coverage their employer provides.	64	73	56	62	69	76
Employers are better able to find the best health plans to offer their employees so employers should continue to choose which plans to provide their employees.	27	21	33	29	26	22

Almost seven in 10 (69 percent) support a proposal to give employees that power by allowing them the option to receive directly the tax break they currently get only if their employer provides them with health coverage. The proposal finds the greatest support among GenXers (86 percent), women with children (79 percent), Wired Workers (77 percent), and Independents (75 percent).

Q: Right now, employees receive a tax break on their coverage because their health benefit is not taxed. What if, instead, employees had the option of receiving this tax break directly so they could choose their own health care plan, rather than just use the plan selected by their employer? Would you strongly support, somewhat support, somewhat oppose, or strongly oppose this proposal?

	All	Dem.	Rep.	Ind.	Wired Workers	GenX	Women w/ kids
Strongly support	34	29	35	38	39	34	40
Support / Oppose	69/21	64/27	67/20	75/19	77/15	86/11	79/15

Providing additional options to employees — such as the ability to purchase coverage through an organization like AARP, their church, union, or a community-based purchasing co-op — pushes support for the proposal still higher, to 72 percent.

Q: What if employees had the option of receiving a tax break they could use to choose their own health care plan, and the option to purchase their health care through an outside organization such as the AARP, union, a church, or a community-based purchasing co-op instead of through their employer? Would you strongly support, somewhat support, somewhat oppose, or strongly oppose this proposal?

	All	Dem.	Rep.	Ind.	Internet Users	GenX	Women w/ kids
Strongly support	31	29	29	34	31	33	33
Support / Oppose	72/18	68/21	75/14	72/18	76/17	84/10	79/14

Indeed, when given the choice, a majority of 51 percent would prefer such a system to the current system. That preference is particularly strong among Independents (60 percent), Wired Workers (57 percent), GenXers (56 percent), and women with kids at home (54 percent).

Q: Which do you prefer?

	All	Dem.	Rep.	Ind.	Wired Workers	GenX	Women w/ kids
Current system in which employers are the primary way people find health plans	37	37	44	32	37	33	38
New system in which people would primarily find health care plans through organizations like the AARP, unions, churches, or community-based organizations	51	49	45	60	57	56	54

Expanding Access to Health Information

Although, as discussed above, most Americans do not have an immediate need for additional information about health plans — in large part because they are satisfied with their doctor — people strongly feel that the government should require health plans to supply information about their success rates and customer satisfaction. Nearly three-quarters (74 percent) say they would use such information to make choices about health plans and doctors. GenXers (84 percent), Wired Workers (82 percent), and Democrats (81 percent), would be the most likely to use this new information.

Q: If the government required health plans and doctors to supply information about how well they take care of their patients and their satisfaction with the care they received, would you use this information to make choices about health plans and doctors?

	All	Dem.	Rep.	Ind.	Wired Workers	GenX	Women w/ kids
Yes	74	81	66	72	82	84	77
No	19	13	25	20	14	13	16

Even in the face of the argument that requiring such information of health plans would create unnecessary bureaucracy and paperwork, a strong majority believe that it is only fair for health insurance companies to disclose more information to consumers.

Q: Which is closer to your view?

	All	Wired Workers	GenX
This would create unnecessary bureaucracy and paperwork and raise insurance costs	32	20	31
Health care companies and doctors should disclose how well they perform so consumers and employers can judge where to spend their money	57	73	62

The premium that people place on disclosure of health information can be gauged by the fact that a majority (57 percent) say it is more important for people to have information about each health plan, hospital, and doctor's success rate and customer satisfaction than it is to have the right to sue. In general, however, an overwhelming majority (84 percent) believe people should have the right to sue their managed care company for damages caused by its decisions on medical coverage.

In contrast to other contexts in which the Internet has helped reduce information gaps, nearly eight in 10 (79 percent) say they have never used the Internet to get health care or treatment information. When it comes to health information, most people simply seem to prefer face-to-face interactions, at least so far. Thus, nearly six in 10 (58 percent) say they are not even interested in corresponding with their doctor over e-mail.

But there is evidence that the appeal of the Internet will soon transform the distribution of health information as well. About one-third of Wired Workers (34 percent), Internet users (32 percent), and GenXers (30 percent) already say they have used the Internet for health purposes; a majority of GenXers (60 percent), Wired Workers (57 percent), and Internet users (56 percent) say they would like to be able to communicate with their doctor by e-mail.

Q: Have you ever used the Internet to get health care or treatment information?

	All	Internet Users	Wired Workers	GenX	Baby Boomers	60+
Yes	21	32	34	30	24	15
No	79	68	65	70	75	85

Q: Would you like to be able to communicate with your doctor by e-mail?

	All	Internet Users	Wired Workers	GenX	Baby Boomers	60+
Yes	38	56	57	60	46	15
No	58	39	39	36	50	81

Reforming Medicare

In many ways, the issues involving Medicare mirror the broader health care issues discussed above. Although 47 percent of the general public say we need fundamental reform of Medicare, those who are in the system — seniors — initially say they are content with the program. Of those 60 and over, 49 percent say we need minor reform of Medicare and only 37 percent say that fundamental change is needed.

Q: Do you think we need fundamental reform of the Medicare system or only minor changes to the system?

	All	60+	Medicare
Fundamental reform	47	37	39
Minor changes	39	49	56

But as is the case with health care generally, people strongly support a proposal that would offer seniors a choice of plans within Medicare and more information to make informed decisions. A total of 85 percent of the public overall and 74 percent of seniors 60 and over years old would favor such a system.

Q: One proposal for Medicare reform would be to give every senior an alternative in which Medicare would contribute enough to cover the cost of a basic insurance plan and provide seniors with information about a variety of health plans they could choose from. Seniors could then choose which plan gave them the benefits, quality, and convenience they need at the lowest cost. Do you strongly support, somewhat support, somewhat oppose, or strongly oppose this plan?

	All	Dem.	Rep.	Ind.	60+	GenX	Wired Workers	Medicare
Strongly support	42	48	36	42	40	34	43	46
Support / Oppose	85/11	83/13	86/8	87/10	74/18	92/7	88/8	76/21

And a majority think that, despite providing more choice, such a system would either save Medicare money (25 percent) or have little effect on Medicare spending (39 percent).

Q: Do you think this proposal is likely to save Medicare money, result in higher Medicare costs, or have little effect on the amount of money we spend on Medicare?

	All	Dem.	Rep.	Ind.	60+	GenX	Wired Workers	Medicare
Save money	25	25	26	24	18	22	27	20
Additional costs	20	21	22	19	21	23	17	19
Little effect	39	32	36	47	38	45	44	47

However, it should be noted in this context that Medicare remains a highly popular program and changes to it are generally viewed extremely cautiously, especially by seniors.

Expanding Uses for Medical Records

Although Americans are very vigilant about ensuring the privacy of their medical records, many are willing to make some of their medical information available, with their privacy protected, if doing so would enhance treatment in general or for them in particular. A total of 59 percent would be willing to release information from their records to help researchers learn how to better address illness. And 75 percent would support making information from their medical files available if it meant that doctors treating them, especially during an emergency, would be able to provide better care. The same groups that support other reforms to the health information system, including Internet users, GenXers, Wired Workers, and women with children, are particularly supportive of these proposals as well.

Q: Would you be willing to make information about you and your health plan available, with your privacy protected, if... [WOULD BE / WOULD NOT BE]

	All	Internet Users	Wired Workers	GenX	Women w/ Kids
Researchers could analyze the same information from you and everyone like yourself to better understand the best way to treat any illness you might have?	59/31	65/26	65/31	66/31	67/24
It meant that doctors treating you, especially during an emergency, would have the information they need to treat you safely and effectively?	75/19	82/16	82/15	84/16	79/16
It meant you would also have easy access to all of your health records?	66/27	70/26	72/26	72/25	68/24

Even when the privacy issue is highlighted as a reason to oppose such proposals, a majority (55 percent) continue to believe that the potential improvements in health care are worth the risk to privacy.

Q: Which is closer to your view?

	All
The chance that making my health records available is too great a potential invasion of my privacy and not worth the potential benefits	37
Making my health information available to researchers will improve the quality of my health care — particularly in an emergency — and the extra access it would give me to my records outweighs the potential risk	55

Broadening Health Education

Americans' general belief that they should have access to better health information extends to their children as well. An overwhelming 85 percent support (70 percent strongly support) adding a health component to early childhood education, beginning in kindergarten and going through high school. Support for this proposal cuts across party lines and is particularly strong among Independents, Wired Workers, and GenXers.

Q: Do you strongly support, somewhat support, somewhat oppose, or strongly oppose children being taught about their health and how to take care of themselves, beginning in kindergarten and going through high school?

	All	Dem.	Rep.	Ind.	Wired Workers	GenX
Strongly support	70	71	64	75	80	79
Support / Oppose	85/11	85/13	84/12	89/9	93/5	91/7

4. Long-Term Care

The issue of long-term care is both troubling and confusing to many Americans, young and old. People do not agree on a single strategy for how they will pay for long-term care. About 30 percent say they intend to use private savings or family resources; 25 percent plan to use Medicare or Medicaid; and 23 percent say they will rely on a private insurance plan. Seniors 60 and over are more likely to say they will rely on government programs such as Medicare and Medicaid (33 percent), while younger Americans expect to rely more on private savings or family resources. Among GenXers, 41 percent say they will depend on savings and only 12 percent say they will depend on the government.

Q: As they grow old, many people need long-term care like nursing home care in addition to health care. How do you plan to pay for your long-term care needs?

	All	60+	GenX	Medicare
From Medicare or Medicaid	25	33	12	36
From private savings or family resources	30	21	41	24
From a private long-term care insurance plan	23	22	33	23
I don't need a plan	7	11	4	3

At the same time, people are divided about whether Medicare and Medicaid even cover nursing home and long-term care. A plurality of 44 percent believe that Medicaid does not cover long-term care, 33 percent believe it does, and close to a quarter (24 percent) are not sure. Similarly, 44 percent believe that Medicare does not cover long-term care, 38 percent believe it does, and 19 percent are not sure.

In fact, Medicaid, a program designed for the poor, covers long-term care and Medicare does not. This misperception over long-term care coverage is less common among people 60 and over, who are more likely to have faced problems with long-term care. Although a third of seniors 60 and over say they plan to rely on Medicare or Medicaid for long-term care, a majority (54 percent) of them are aware that Medicare does not cover long-term care, and they are almost evenly divided on whether Medicaid covers long-term care (38/42 percent). The fact that nearly four of every 10 people (38 percent) believe that Medicare covers long-term care explains why many people do not see the need to buy coverage before they get too old.

Q: Do you think Medicare covers expenses for nursing home care and long-term care, or not?

	All	60+	GenX	Wired Workers	Medicare
Yes	38	34	42	38	37
No	44	54	42	45	48

Q: Do you think Medicaid covers expenses for nursing home care and long-term care, or not?

	All	60+	GenX	Wired Workers	Medicare
Yes	33	38	35	30	44
No	44	42	46	46	33

A proposal to encourage people to buy private insurance for long-term care and to help those who cannot afford such coverage garners good support, but older Americans are wary. Less than half would support such a plan.

Q: Today, Medicaid pays for long-term care for people who are too poor to afford it themselves or who rearrange their finances to qualify. Would you strongly support, somewhat support, somewhat oppose, or strongly oppose a different system in which the federal government encourages everyone to buy private, long-term insurance and subsidizes those who cannot afford it?

	All	60+	GenX	Wired Workers	Medicare
Strongly support	28	25	23	25	29
Support / Oppose	61/30	48/37	61/34	64/31	58/29

To date, the question of long-term care simply has not been debated enough publicly for people's views to crystallize on the topic. But given the confusion over the issue, and the potentially catastrophic impact long term care can have on a family's finances, this is an issue that deserves increasing attention in the future.

Contributing Photographers: AP/Worldwide Photos – 21, 43, 56, / Archive Photos – 5,15, / Corbis Images – 13, 22, 45, / FPG – inside cover, 7, 49, 53, 63, / Globe Photo – 30, / Image Bank – front cover, 11, 18, 23, / Impact Visuals – 9, 36, / International Stock – 42, 46, / Magnum Photos – Fred Mayer 54, / Photonica – 25, 61, / Stock Market – 16.

Postscript

by David Kendall and S. Robert Levine, MD

Governing the ungovernable health system

A universal health care system has been a key progressive goal since Theodore Roosevelt's day. In 1994, the quest for comprehensive reform once again rose to the top of the nation's agenda, only to collapse under pressure from partisan conflict, skepticism toward the proposed role for government, and an overly complex blueprint for change. What will it take to get the job done at last?

Strong leadership. By early 2000, both Vice President Gore and Sen. Bradley had demonstrated their commitment to making reform happen. The Republican presidential candidates had not yet proposed systemic reform or a major expansion of health care insurance but had recognized health care as a priority for voters.

Bipartisanship. In an era of divided government, progress is possible only if the two political parties stop indulging their ideological extremes and find common ground. The best starting point for an agreement is a tax credit for the uninsured because it already has bipartisan support in Congress.

Step-by-step reform. As the abortive 1994 health care debate showed, reform should not be attempted in one fell swoop. But neither should we be satisfied with progress around the margins. The series of large steps laid out in this BLUEPRINT will culminate in a universal system in which all Americans have access to, and take responsibility for securing, their health care coverage and long-term care insurance.

Public support. Each step of reform as well as its final goal must make sense to people. Penn's Poll shows broad public support for change — including far-reaching reforms like requiring all Americans to have health insurance.

Minimal disruption. Health care reform must respect the fact that most people are happy with their current coverage and doctor. That means, for instance, that we should supplement, not replace, job-based coverage, giving people the option of buying their own insurance if they choose. Those without employer-based insurance should be enabled to play on a level playing field, with

equivalent tax treatment of coverage costs and access to group purchasing power.

Fiscal discipline. As the demand for health care grows, we must promote the most efficient use of finite health care resources. The unique opportunity presented by growing budget surpluses should not be squandered on health care that produces little bang for the buck. Achieving the full value of health care requires continuous innovation, new research to determine what interventions are effective, and consumer responsibility.

Consumer empowerment. Health care reform should empower consumers, not institutions. For too long, the government has merely arbitrated fights between competing groups: doctors, managed care companies, lawyers, hospitals, etc. Real consumer empowerment means giving consumers more control of their health care purchasing power, more information, and more choices.

Self-governance. America's vast health care economy — \$1.1 trillion — is too complex and too dynamic for the government alone to solve all problems. No central authority can single-handedly manage health care in the Information Age. Instead, government must level the playing field and help create the framework in which an empowered consumer and an open marketplace can create value

and quality for everyone. Rather than trying to legislate incremental fixes, the government must enhance the system's self-adaptive capacity by producing new knowledge, facilitating information sharing, building communities of support, and connecting people with resources. A good example of bringing together diverse groups around a common purpose is the imaginatively-spelled Vvaleo initiative supported by the Department of Veterans' Affairs. Derived from a Latin word meaning "to be in good health," Vvaleo has the potential to solve many systemic problems, including the challenge of making medical records highly secure yet easily available to those who need them, including patients. ■

"Reform should not be attempted in one fell swoop. But neither should we be satisfied with progress around the margins."

Ideas that work ...

DLC IDEAS are bold, innovative, and in tune with the times; they promote **TRADITIONAL VALUES** like opportunity, responsibility, and community; and, most importantly, they work. Ideas developed or promoted by the **DLC** and put into action by **PRESIDENT CLINTON** — an economic strategy of fiscal discipline, expanded trade and investments in people; expanding the earned income tax credit; **REPLACING WELFARE** with a system of work; **REINVENTING GOVERNMENT**; community policing; national service — are improving the lives of tens of millions of our fellow citizens.

The challenges ahead ...

As a new century approaches, America faces daunting **NEW CHALLENGES**: to assure American leadership in a world economy; to build a world-class education system; to provide retirement security for generations to come; and to equip citizens with the skills they need to prosper in the **NEW ECONOMY**.

These are tall orders. Politics as usual will not do.

"These words — opportunity, responsibility, community — came to identify and embody a new approach to government and politics, tying our oldest, most enduring values to the Information Age... We said we were New Democrats, and we called our approach the Third Way... These same ideas are reviving center-left political parties throughout the industrialized world as people everywhere struggle to put a human face on the global economy... and it all started with the DLC... Today, less than 15 years after we started, the ideas pushed by the DLC are literally sweeping the world."

PRESIDENT BILL CLINTON, DECEMBER 2, 1998

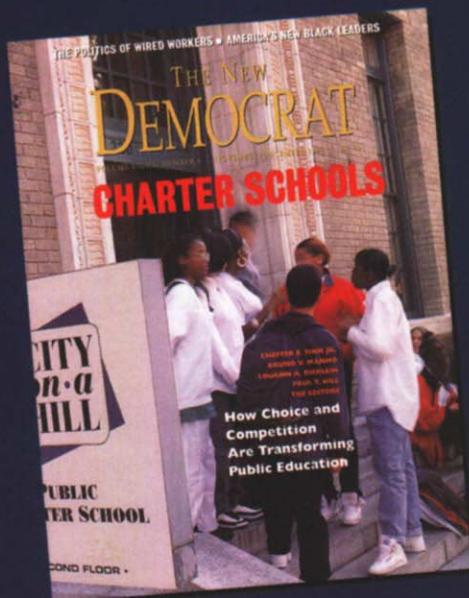
**JOIN THE NATIONAL NETWORK OF THOUSANDS OF LEADERS
WORKING TO TURN NEW DEMOCRAT IDEAS INTO ACTION.**



Membership is \$50, \$20 for students.

Phone: 800-546-0027 or in the Washington, DC metro area 202-544-6172 **Fax:** 202-544-5002

E-mail: webmaster@dlcppi.org Visit our Web site at <http://www.dlcppi.org/joinform.html>



THE NEW DEMOCRAT

The DLC flagship publication, published bimonthly. Its unique perspective spares neither Right nor Left, and gives you the substance, analysis, and arguments to challenge both.

To order a subscription to The New Democrat, please mail, fax, or email a written request to:

Democratic Leadership Council/TND

PO Box 15823

Washington, DC 20078-0800

You can also order on the web at: www.dlc.org

For fastest service, call **1-800-546-0027**.

An annual subscription to The New Democrat is \$18 (USD).



**Democratic Leadership Council
Blueprint
600 Pennsylvania Avenue SE
Washington, DC 20003**



Non-Profit Organization
U.S. Postage Paid
Permit 3775
Washington, DC